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Women's Health as State Strategy: Sri Lanka's Twentieth Century

By

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Abstract

Sri Lanka gained prominence in international policy circles as an apparent 'success story' first as a model colony in early 1950s and later as a development model for South Asia by 1970s. In naming Sri Lankan 'success story' experts pointed to the decreasing population growth rate and decreasing mortality. Renowned demographers attributed this to the improvements in the field of social indicators such as high literacy rates, increased life expectancy and rise in female age at marriage. In this 'success story' women's health serves as a linchpin to the attainment of national progress. But a focus on women's health – as statistics and indicators – has also served to silence questions about Sri Lankan women's broader experiences of their disaggregated health. In particular, while Sri Lankan 'women's health' served the Sri Lankan state's 'success story' well, what is less clear is how women's individual bodies have fared within subsequent tellings of its other twentieth century Sri Lankan stories of late colonial, national, developmental, neoliberal and militarised phases.

My thesis examines this question through a critical examination of women's health history of this island nation. I trace its history from initial birth control, family planning (1953) to development population control to militarisation, financialisation of women's bodies and ends with a critical examination of recent policies that claim to emancipate women's health 'beyond' a myopic focus on their role as reproducer.

Although women's health was vigilantly 'controlled' and 'planned' for the state building project and women's bodies were framed around the notion of social reproduction for the nation building project of post independent Sri Lanka, women were neither subjects nor objects of these two projects. Women's reproductive bodies were, rather, the ground for a complex and competing set of struggles on population, family planning, development, modernisation and ethno nationalism of post independent Sri Lanka. Further women's health/women's bodies analysis helps to elucidate the manner in which we can track the operation of power that serves to silence women's own corporeal subjectivity and to delimit the realms in which she can exercise her own agency.

Abbreviations

ACWC-	All Ceylon Women's Conference
CML -	Countway Medical Library
DTRU -	Demographic Training and Research Unit
FDA -	Food and Drug Administration
FHB -	Family Health Bureau
FPA -	Family Planning Association
GDP -	Gross Domestic Product
ICPD -	International Conference on Population and Development
IMF -	International Monetary Fund
IPPF -	International Planned Parenthood Federation
JVP -	Janatha Vimukthi Peramuna (People's Liberation Movement)
LGBT -	Lesbian, Gay, Bisexual and Transgender
LOC -	The Library of Congress
LSSP -	Lanka Samasamaja Party (Socialist Party of Sri Lanka)
LTTE -	Liberation of Tamil Tigers of Eelam
MCH -	Maternal and Child Health
MDL -	Mothers and Daughters of Lanka
MOH -	Medical Officer of Health
PA -	Peoples' Alliance
PAA -	Population Association of America
PHM -	Public Health Midwife
PHNS -	Public Health Nursing Sister
PRH -	Population and Reproductive Health
RG -	Record Group
SAP -	Structural Adjustment Policies
SIDA -	Swedish International Development Cooperation Agency
SLFP -	Sri Lanka Freedom Party
SPC -	State Pharmaceutical Corporation of Sri Lanka
UNP -	United National Party
USAID -	United States Agency for International Development
WID -	Women in Development
WWC -	Well-Woman Clinic

Chronology of Events

- 1948 – Ceylon gained independence from the British Empire. The first Prime Minister was D.S. Senanayake of the United National Party (UNP)
- 1953 – The Family Planning Association (FPA) of Ceylon was established by a group of elite women
- 1956 – Sri Lanka Freedom Party (SLFP) was formed by S.W.R.D. Bandaranaike and he was elected the Prime Minister
- 1956 – Sinhala Only Act was introduced
- 1958 – The first major riots between Sinhalese and Tamils flared up in Colombo
- 1959 – The Prime Minister S.W.R.D. Bandaranaike was assassinated
- 1960 – Mrs. Bandaranaike took over as the first female Prime Minister of the world
- 1961 – The Pill clinical trials were conducted at the De Soysa Maternity Hospital in Colombo
- 1965 – Ministry of Health took family planning on board
- 1971 – First Youth Insurrection in Ceylon. Also known as Janantha Vimukthi Peramuna (JVP) uprising.
- 1972 – Ceylon became a Socialist Republic of Sri Lanka
- 1974 – The FPA launched the *Mithuri* Programme
- 1977 – Sri Lanka opened its economy to capitalist market forces under J.R. Jayawardena of UNP. He amended the constitution in 1978 and became the first executive president of Sri Lanka
- 1983 – Communal riots started and flared up to an ethnic war over the years
- 1989 – Second JVP uprising in the South. Ranasinghe Premadasa was elected the President of Sri Lanka
- 1993 – Premadasa was assassinated
- 1994 – Chandrika Kumaratne was elected President of Sri Lanka under the SLFP
- 2005 – Mahinda Rajapakse was elected as the President of Sri Lanka
- 2009 – Ethnic war ended under Mahinda Rajapakse's leadership

Introduction

Since the 1970s, internationally renowned demographers, development economists and health experts hailed Sri Lanka as a 'development model', based on low fertility and mortality levels, increasing life expectancy, commendable women's literacy rates, and sound public health services.¹ In heralding Sri Lanka's 'success story', experts pointed to the decrease in the country's population growth rate from 3 percent per annum in the late 1950s to 2.2 percent by the late 1960s.² Based on the mortality decline observed in 1954, Western demographers declared that Sri Lanka was 'only a generation behind' in attaining the development profile held by economically advanced countries. This was particularly notable given the same development experts' judgment of Sri Lanka's regional neighbours: India was 'three generations behind,' while Pakistan and Burma were deemed to lag two centuries behind the West.³

Yet this was not the first time Sri Lanka had been singled out for its 'advancement'. Sri Lanka has been considered a 'model' since the colonial period. By the late 1940s, British colonial administrators and constitutional policy reformers such as Sir Charles Jeffries (permanent under-secretary at the Colonial

¹ Dudley Kirk, 'Natality in the Developing countries: Recent Trends and Prospects,' in *Fertility and Family Planning a World View*, edited by S.J. Behrman, Leslie Corsa and Ronald Freedman The University of Michigan Press, 1969, p. 80; Caldwell, J.C., Gajanayake, I., Caldwell, B. and Caldwell, P., 'Is marriage delay a multiphase response to pressures for fertility decline? The case of Sri Lanka,' in *Journal of Marriage and the Family* 51 (May 1989): pp. 337–351 and p. 338; Alam, I. and Cleland, J. C. (1981) *Illustrative Analysis: Recent Fertility Trends in Sri Lanka*. World Fertility Survey Scientific Report No. 25. International Statistical Institute, Voorburg and Gunnar Myrdal, *Asian Drama: An Inquiry into the Poverty of Nations, Vol. II*, New York, Pantheon, 1968.

² Gamini Corea, 'Ceylon in the Sixties', in *Marga Quarterly*, Vol. 1 No. 2, 1971, p. 2.

³ Gunnar Myrdal, *Asia Drama: An Inquiry in to Poverty of Nations, Vol. II*, New York, Pantheon, 1968, p. 1408.

Office from 1945 to 47) identified Sri Lanka as a 'model colony' due to the strength of its civil society, the political maturity and sophistication of its leaders, and above all for the fact that it had granted universal adult suffrage by 1931.⁴

Sri Lanka's rapid progress towards political modernity was understood to be in part the result of its educational infrastructure—an infrastructure that served both boys and girls. Not only Sri Lankan men but also elite Sri Lankan women were politically active in gaining their franchise. The Women's Franchise Union was formed in 1927 by a group of professional women—many of them were wives of nationalist and labour party leaders. Among the pioneering women of the franchise movement were doctors, teachers and lawyers. This was possible in part because Baptist and Methodist missionaries from the American Mission and the Church Missionary Society established schools for Sri Lankan girls from the 1820s. Local languages (Sinhalese and Tamil) were the medium of instruction in schools for the poor and English for the economically privileged.⁵ The Ceylon Medical College was inaugurated in 1870 in Colombo, and the first female student was admitted in 1892. The English Training College for teachers was opened in 1902 and the first women were admitted in 1908.⁶

⁴ Sir Charles Jeffries quoted in K.M. de Silva, 'The Model Colony'; Reflections on the Transfer of Power in Sri Lanka', in A. J. Wilson and Dennis Dalton (eds), *The States of South Asia; Problems of National Integration*, London, C. Hurst & Company, 1982, p. 83.

⁵ Kumari Jayawardena, *Feminism and Nationalism in the Third World*, London, New Jersey, Zed books Ltd, 2003, p. 118. See also Swarna Jayaweera 'Women in Education and Employment - Fifty Years in Retrospect,' in Swarna Jayaweera (ed.), *Women in Post-Independence Sri Lanka*, (Sage: 2002) for the history of women's education in Sri Lanka.

⁶ Jayawardena, *Feminism and Nationalism*, p. 121.

These achievements of civil society were possible not only due to the state's welfare policy in education but also its health policy. By the 1950s, Sri Lanka became the template to be followed by other nations of the region to develop their public health care.⁷ Western demographers became interested in Sri Lanka in the 1950s because Sri Lanka was able to successfully bring down mortality rates. According to one economist/development expert, the mortality rate was brought down to 66.1 per 100,000 population in 1947 from 187.3 in 1946, due to the efficient anti-malaria campaign launched in Sri Lanka, in 1946.⁸ Observing the health care system in Sri Lanka, Myrdal says,

[o]f the countries with the greatest health problems and the highest mortality in South Asia, and in the world, India has achieved remarkable results in public health work since 1950. Indeed, India's achievements suggest that, with time and effort, these countries too could duplicate the experience of Ceylon.⁹

Myrdal believed that the diligent efforts in public health by the colonial administration and later by the post-colonial state have shown progressive results in Sri Lanka, which could be used as a template for South Asia. In turn, renowned demographers attributed these demographic improvements to pre-existing social indicators such as high literacy rates, rise in female age at marriage, and increased life expectancy at birth. Female literacy rate rose from 44 percent in 1946 to 67.3

⁷ Gunnar Myrdal, *Asian Drama: An Inquiry in to Poverty of Nations, Vol. II*, New York, Pantheon, 1968, p. 1419.

⁸ Gunnar Myrdal, *Asian Drama: An Inquiry in to Poverty of Nations, Vol. III*, New York, Pantheon, 1968, p. 1569.

⁹ Myrdal, *Asian Drama, Vol. II*, p. 1419.

Ceylon became Sri Lanka in 1972 when it was granted dominion status by the British Empire. Since both terms refer to the same geographical entity I use the terms Ceylon and Sri Lanka interchangeably in my thesis.

percent in 1963 and 83.2 percent in 1981.¹⁰ Noting the rise in female age at marriage, Caldwell says that 'by the mid-1970s Sri Lankan women were marrying not at puberty, but a decade after.'¹¹ Life expectancy at birth rose from 60 in 1960 to 67 in 1980.¹²

As a historian, I wish to disturb and question the tranquillity with which this 'success story' is accepted.¹³ By doing so, my aim is to illuminate the simultaneous subjugating processes through which this 'success story' of women's health has been produced in Sri Lanka.

Research Problem

In this 'success story', 'women's health' serves as the linchpin to the attainment of Sri Lanka's national progress. But a focus on women's health—as defined by statistics and indicators—has also served to silence questions about Sri Lankan women's broader experiences of their disaggregated health. In particular, while official indicators of 'women's health' had served the Sri Lankan state's 'success story' well, what is less clear is how women's individual bodies have fared within Sri Lanka's other twentieth - century stories. I am particularly concerned here

¹⁰ W. D. Lakshman and Clement Tisdell, 'Introduction to Sri Lanka's Development Since Independence in Lakshman, W.D. and Tisdell, C.A. (eds), *Sri Lanka's Development Since Independence: Socio-economic perspectives and Analysis*, New York, Nova Science Publishers, 2000, p. 5 and <http://www.statistics.gov.lk/social/social%20conditions.pdf> (Accessed on 13 Dec. 2012).

¹¹ Caldwell, J.C., I. Gajanayake, B. Caldwell, and P. Caldwell, 'Is Marriage Delay a Multiphasic Response to Pressures for Fertility Decline? The Case of Sri Lanka', *Journal of Marriage and Family* 51:2(1989).

¹² Myrdal, *Asian Drama: Vol. II*, p. 1422.

¹³ <http://www.marxists.org/reference/subject/philosophy/works/fr/foucault.htm> (Accessed on 21 Nov. 2012).

with how women's health and the Sri Lankan 'success story' has been mobilised in our commonsensical understandings of its late colonial, national, developmental, neoliberal and militarised periods. What emerges from my study is that women's health statistics have become so dominant in explaining this 'success' that they have managed to mask the processes that were muting and silencing women's bodies—both their individual and collective corporeal experiences.

The term 'woman's body' or 'discourses on woman's body' in my thesis denotes a particular ideology framed through nationalist discourses in colonial Sri Lanka. It is part of a broader project where woman's body was disciplined and its margins of revelation were demarcated in colonial Sri Lanka. This particular ideology has influenced and still influences women's perception of their bodies and reproduction (both biological and social). An understanding of 'woman's body' ideology is essential to explore these subjugations through which women's health 'success story' has been produced in Sri Lanka. I will be addressing the concept of 'woman's body' at length later on in the introduction – both in general and in terms of its specific relationship to and relevance for the Sri Lankan case. My thesis seeks, then, to situate both the 'women's health' discourse and 'discourses on woman's body' within a unified analytical framework in the aim of providing a broader insight to understand Sri Lanka's 'success story'.

My thesis analyses the women's health 'success story' through a critical reconstruction of the history of women's health policy and practice in modern Sri Lanka—from family planning to reproductive health and rights (1953–96). Instead

of considering this 'success story' through demographic or development discourses, I propose to read women's health and population policy documents 'against the grain', drawing attention to issues of women's health and women's bodies that demographers, family planners, development experts, economists and policy makers of Sri Lanka so far refused to recognise and conveniently and consistently ignored. This 'success story' was carefully constructed by demographers, family planners, development experts, economists and policy makers of Sri Lanka by treating women's health purely as a statistical indicator, disregarding the essentiality of corporeal experiences of women when implementing women's health policies such as population control and family planning activities. Thus my project of writing a critical history of women's health in modern Sri Lanka is neither a history of the Family Planning Association of Sri Lanka nor a demographic history.¹⁴ Instead it is an evaluation of how the state deployed women's health in the post-colonial state building and nation building projects of Sri Lanka while silencing women's corporeal experiences. Thus, my study is situated at the intersection of a number of scholarly fields including population studies, development studies, women's studies and the history of medicine. This study both frames a discursive institutional history of women's

¹⁴ For a history of FPA of Sri Lanka see O.E.R. Abhayaratne and C.H.S. Jayawardena, *Family Planning in Ceylon*, Colombo, The Colombo Apothecaries Ltd., 1968; Nicholas H. Wright, 'Early Family Planning Efforts in Sri Lanka,' in Warren C. Robinson and John A. Ross (eds), *The Global Family Planning Revolution: Three Decades of Population Policies and Programmes*, Washington DC: World Bank, 2007, pp. 341–362; and Kumari Jayawardena, *Dr. Mary Rutnam: A Canadian Pioneer for Women's Rights in Sri Lanka*, Colombo: Social Scientists' Association, 1993.

health in Sri Lanka, and suggests a new set of material and discursive categories for the writing of modern Sri Lanka's new critical histories.

Objectives of the Research

Considering how central the discourses on woman's body are to most of the above mentioned scholarly work on Sri Lanka, it is surprising that they have not been critically investigated before. Perhaps this indicates the success of the women's health discourse in becoming 'common sense' when it comes to understanding women and modernity in contemporary Sri Lanka. In light of this, the main objective of my research is to highlight the danger in accepting the women's health 'success story' in tranquillity as 'common sense' knowledge today. By doing so, I unravel how politics of population control, family planning, development, nationalism and the neo-liberal market have both produced and have been produced by the women's health programme of Sri Lanka.

Further, my thesis addresses two distinctive and rather broad objectives. First, my thesis traces the history of the women's health discourse by paying attention to those historical moments where women's bodies are mobilised, but not emancipated. By pointing out the discursive and policy disconnect between women's health and discourses on woman's body in Sri Lanka, my project provides a new approach to the study of women's health and women's history in Sri Lanka.

The other objective of this project is to interrogate the paradigm shift - 'beyond reproduction' - that lies at the heart of the contemporary women's health

discourse. In the wake of the International Conference on Population and Development (ICPD) held in Cairo in 1994 which attempted to critique approaches to women's health restricted to reproduction, a new paradigm emerged 'beyond reproduction'. What this term would mean in health policy and practice was less clear. In the Sri Lankan context, 'beyond reproduction' presented an apparent about-face in approaches to women's health, as the new concept disturbed the orthodox view that women's health was necessarily reproductive health. In Sri Lanka, the shift manifested by the launch of a Well-Woman Clinic programme in 1996 that focused on the early detection and treatment of non-communicable diseases such as cervical cancer and breast cancer. By interrogating the concept of women's health 'beyond reproduction', I am trying to understand why it has proved so difficult in Sri Lanka to disentangle women's health from the Malthusian ideology of 'controlling and planning', and women's bodies from biological and social reproduction.

Historiography of Development, Modernisation and Women's Health

At the global level, the development 'success story' of Sri Lanka is understood as a by-product of the development and modernisation projects put forward by American economists and demographers in the post-World War II era. Therefore it is necessary to first engage with the historiography of development and modernisation in order to provide the background to Sri Lanka's entry into the modernisation process along with other Third World countries. Then I will

critically discuss the term ‘discourses on woman’s body’, its contested character, the critiques put forward by historians and the way in which discourses on women’s health and woman’s body exist in mutual exclusion of one another. This is the gap that I attempt to close through my research, bringing these two discourses into a single analytical framework. In my opinion, it is essential to bring out the muted stories of women’s corporeal experiences in order to understand the complexity of the discourse on women’s health, which provides the base of the development ‘success story’ of independent Sri Lanka.

Development, Modernisation and Women’s Health

The American economic historian W.W. Rostow put forward his thesis in *The Stages of Economic Growth: A Non-Communist Manifesto*, in 1960. This came out at the historical moment when the field of ‘development’ was taking shape. According to Rostow, economic development or modernisation is the final destination of development, which is marked by mass consumption. This is the path he prescribed for countries to follow in order to overcome the chaos created by the World War II. His seminal work primarily conveys two messages about US defence and foreign policies: first, the USA should assist other countries in their development projects in order to perpetuate capitalism, and, second, the USA should concentrate on containing the spread of communism especially in the newly independent states of Africa and Asia. Due to his academic and political

affiliations during the 1950s and the 1960s, this hypothesis had an enduring influence on a whole generation of economic and development planners.¹⁵

According to Rostow's economic growth theory population growth was seen coterminous with poverty, destitution, traditional, underdeveloped and pro-communist. Thus demographers' assistance was sought by US policy makers to formulate a population control policy to develop the underdeveloped world. Hodgson points out that in this endeavour a generation of demographers shifted from a social science perspective to a policy oriented one in the 1940s and 1950s.¹⁶ Frank Notestein and Kingsley Davis, professors of the Office of Population Research at the University of Princeton, were the two most influential demographers engaged in the formulation of population control policies. Together they developed the modern demographic transition theory in 1945 and according to many it provided the much needed justification for development policy makers to curb population growth in the Third World.¹⁷ Notestein and Davis' modern

¹⁵ Walt Whitman Rostow became professor of economic history at the Massachusetts Institute of Technology in 1950. A year later he received a dual appointment as a professor at MIT's Center for International Studies funded by the CIA. In 1960, Rostow became the deputy special assistant for national security affairs in the Kennedy administration. From 1961 to 1966 he became the chairman of the Policy Planning Council under the administrations of both Kennedy and Lyndon B. Johnson who became the president following Kennedy's assassination in November 1963. Further he played a prominent role in shaping US foreign policy in South East Asia in the 1960s. http://www.anb.org/articles/14/14-01158.html?from=../07/07-00152.html&from_nm=Kennedy%2C%20John%20Fitzgerald (Accessed on 2 March 2013).

¹⁶ Dennis Hodgson, 'Demography as Social Science and Policy Science,' in *Population and Development Review*, Vol. 9, No. 1 (Mar., 1983), p. 2. (pp. 1–34).

¹⁷ The demographic transition theory was introduced in 1929 by American demographer Warren Thompson through his careful study of birth and death rates of industrialised countries over a period of 200 years. This was further developed in late 1940s by Frank Notestein and Kingsley Davis of the Office of Population Research at the University of Princeton. According to Notestein and Davis, the modern demographic transition theory means that 'the shift towards low mortality and fertility rate occurs when there is a process of overall modernisation resulting from industrialisation, urbanisation, education, empowerment of women, as well as substantial overall

demographic transition theory appeared as a 'social engineering' project, placing 'all countries on a grand evolutionary scheme running from pre-transitional ("traditional") to transitional to post-transitional ("modern").'¹⁸ Rostow's economic growth theory also put the countries on an evolutionary scheme running through five stages of growth from traditional society, to the preconditions for take-off, then the take-off, then the drive to maturity, and the final stage is high mass-consumption. By sharing the same set of assumptions, the logical end point of both these theories inevitably became capitalism. Further both these theories perceived population growth as an indication of a traditional society or initial stage of the evolutionary scheme towards development. In other words the modern demographic transition theory supported Rostow's growth theory. Both these theories together became a unique explanatory model to develop the backward, non-industrialised societies of the Third World.¹⁹ According to this explanatory model, it was imperative to control and plan the traditional populations of the Third World in order to develop and modernize these countries. Controlling and planning of the population was new to traditional societies in the 1950s. Thus it became imperative for the First World to intervene in population planning of the

socio-economic development.'

http://www.uneca.org/publications/FSSD/State_of_Demographic_Transition_in_Africa.PDF, p. 1 (Accessed on the 13th June 2009.)

¹⁸ Susan Greenhalgh, 'The Social Construction,' p. 36, and John Caldwell, 'Toward a Restatement of Demographic Transition Theory,' in *Population and Development Review*, Vol. 2, No. 3/4 (Sep. - Dec., 1976), p. 323 (pp. 321-66).

¹⁹ According to Rostow, in order to become a capitalist society, every society has to go through five stages of growth from traditional society, to the preconditions for take-off, then the take-off, then the drive to maturity, and the final stage is high mass-consumption. He played a prominent role in shaping US foreign policy in South East Asia in the 1960s.

Third World in order to maintain their capitalist economies in order to rebuild post-Second World War Europe. A budget allocation to fund population control programmes in the Third World became a foreign policy decision in the Western countries in order to maintain their status quo. The Rockefeller Foundation and the Ford Foundation in the US and the Swedish International Development Agency (SIDA) were the pioneers in funding population programmes of the Third World. Scott's concept of 'legibility' is useful here to understand how Sri Lanka entered into the modernisation discourse through these interventions of social engineering nature.

In his critique of the modernisation project, Scott explains that it is imperative for modern states to make traditional societies 'legible' in order to effectively carry out the intervention programmes of social engineering nature in the Third World.²⁰ Identifying 'legibility' as the main distinction between pre-modern and modern states he contends that pre-modern state (or traditional societies) was partially blind. Because,

it knew precious little about its subjects, their wealth, their landholdings and yields, their location, their very identity. It lacked anything like a detailed "map" of its terrain and its people. It lacked, for the most part, a measure, a metric, that would allow it to "translate" what it knew into a common standard necessary for a synoptic view.²¹

According to Scott's definition, by late nineteenth century, colonies of the British Empire (including Sri Lanka) entered into the modernisation discourse through

²⁰ J.C. Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*, New Heaven and London, Yale University Press, 1998, p. 2.

²¹ Ibid.,

census enumeration. In 1871 the British colonial administration carried out the first census of Sri Lanka. This helped the Empire to translate the knowledge about the subject societies into a 'standard synoptic view'. The empire made its colonies 'legible' enough to extract taxes and carry out infrastructural development— transportation, communication, education and health— necessary for an uninterrupted supply of raw materials and markets of the imperial regime.

This 'legibility' was the ground on which demographers and economists understood and designed population policies in post-World War II era with the aim of organising the world. Through these programmes women's reproductive bodies became legible to international organisations. Due to this 'legibility' funding agencies of the First World were able to design, fund, evaluate and monitor women's health programmes in the Third World.

Influenced by the global population discourse, a non-governmental organisation—the Family Planning Association of Ceylon—introduced population control and family planning programmes to Sri Lanka as a welfare measure in the early 1950s. Local policy makers, economists and family planners diligently carried out these programmes which helped Sri Lanka to become a development 'success story' in the region.

Fuelling the 'controlling and planning' approach, women's health scholarship in Sri Lanka focuses more on issues related to reproduction, such as emotional disorders of women during their reproductive age, effects of antenatal Body Mass Index (BMI) on pregnancy and its outcome, women's reluctance to go

for hospital deliveries, women's attitudes on contraceptive methods, and evaluation of the safe motherhood initiative.²² An overemphasis on reproduction is clearly manifest in these issues. These studies have been conducted using mainly quantitative surveys with the intention of improving maternal health care and reducing infant mortality rates.²³ They aim to look at women's health—mainly their ability to reproduce—within the population–development framework in order to develop the country, advocated by the West for more than five decades.

Furthermore, the disciplines that engaged with issues of women's health such as health economics, medical sociology and community medicine focus more on local issues in small communities rather than on questioning the public health system, the welfare state and the neo-liberal market forces that have a profound

²² P. Lukumar and A. Pathmeswaran, 'Factors associated with home deliveries in Thampalakamam, Trincomalee,' in *The Ceylon Medical Journal* 51 (2): 59–62, 2006; N. de Silva, *A Study of Emotional Disorders in Women Patients in General Practice*, unpublished PhD thesis submitted to the Post-Graduate Institute of Medicine, Colombo, 1989; S.M.P. Chandrarathne, *Effect of Antenatal Body Mass Index on Maternal and Foetal Outcome*, unpublished PhD thesis submitted to the Post-Graduate Institute of Medicine, Colombo, 2004; and K.N.J. Fernando, *Knowledge and Practices on Contraception Among Married Female School Teachers in Udunuwara MOH Area and the Use by Them of Available Family Planning Services*, unpublished PhD thesis submitted to the Post-Graduate Institute of Medicine, Colombo, 1999; and H. Seneviratne and L. Rajapakse, 'Safe Motherhood in Sri Lanka: a 100 years March,' *International Journal of Gynecology and Obstetrics*, 10:1(2000), p. 116. (pp. 113–124).

²³ My interviews/conversations with the chairman of the women's research committee at the Sri Lanka Medical Association and lecturers at the medical faculty on different occasions over the past 6 years testify that there are very few studies done on health related issues from a social science perspective. From their experience at the Medical Faculty in Sri Lanka, my informants said, medical students prefer research from a clinical perspective, giving preference to lab work and quantitative methods, they are not trained to look at the human body as a subjective phenomenon, their perception of the body is very limited, they are not exposed to a multidisciplinary approach like in other universities of the world where they could expand their knowledge and perception of human body by mingling with students of other disciplines, and they have a condemnatory view towards social science research, so they hesitate to undertake multidisciplinary research. (I interviewed them for the first time during my MA and then had conversations with them at different stages of my PhD research).

impact on health as a basic right of women in Sri Lanka.²⁴ Women's bodies, women's experiences and women's *métis* about their bodies have not come up as categories and have rarely been problematised in medical and health research in Sri Lanka.²⁵ The myopic nature of medical and health scholarship in Sri Lanka is not helpful in addressing my question about the women's health 'success story'. In the demographic and development approach, women's health is treated as numbers in state statistics, reflecting the country's performance within the linear prescribed progress towards development. Modernity, development and family planning became common-sense terms in the 1950s, and questioning their 'fundamental truth' appeared totally irresponsible and irrelevant. However, my approach to women's health goes beyond statistics. I look at it as the sum total of the discourses on the woman's body, women's corporeal experiences and their feelings towards motherhood and having a family.

Prior to interrogating the particularities of scholarship on woman's body in Sri Lanka it is necessary to briefly discuss the existing literature on the topic in

²⁴ De Silva, A., (co-author with multiple authors) *Investing in Maternal Health: Learning from Malaysia and Sri Lanka*, Human Development Network, Health, Nutrition and Population Series, World Bank, Washington, 2003; De Silva, A., 'Overview of the Health Sector', in Saman Kelegama (ed.), *Economic Policies in Sri Lanka: A festschrift in honour of Gamini Corea*, New Delhi: Sage Publications, 2004; Liyanage D.T.P and Seneviratne, R.D.A., 'Evaluation of cervical screening coverage in Kalutara district', *Journal of College of Community Physicians of Sri Lanka*, 14(1) 2009, pp. 33–38; Suraweera, S., Seneviratne, R.D.A. and Herath, H.M.S.S. D., 'Prevalence of Occupational Stress in Selected Categories of Employees in Domestic Commercial Banks in a District of Sri Lanka', paper presented at the International Conference on Psychosocial Factors at Work, Bangkok, 2009; and Abeysena, C., Jayawardena, P., and Seneviratne, R.D.A., 'Maternal sleep deprivation is a risk factor for gestational age: A cohort study', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 49(2009), pp. 382–87.

²⁵ James C. Scott in *Seeing Like a State* (1998) uses the term *métis* to refer to the knowledge that can come only from practical experience.

general to show how my thesis uses these larger debates to investigate the discourses on woman's body in Sri Lanka.

Literature on the Woman's Body

Theorists on the body acknowledge the influence of feminism as a political movement on the emergence of the body as a topic.²⁶ Feminists brought the body to the forefront in their analysis of power relations under patriarchy. The woman's body is a widely interrogated and analysed concept in medical sciences (medical anthropology, sociology of health and clinical studies) and studies on population, development, nationalism, colonialism modernisation and gender/women's. Each of these disciplines takes an interest in women's bodies because of their biological, social, economic, political and national significance. I will discuss briefly the larger debates put forward by these disciplines, which I draw on in my investigation into the woman's body in Sri Lanka.

Within medical sciences, the woman's body is studied as a biological reproductive body. Studies have discussed the making of the natural, women centred event of child birth into a male dominated medical issue - treating pregnancy as a disease and issues on menstruation - with the development of gynaecology.²⁷ Oakley points out that, by the mid-1950s pregnancy had become a

²⁶ Kathy Davis, *Embodied Practices, Feminist Perspectives on the Body*, London, New Delhi: Sage Publications Ltd., 1997, p. 4.

²⁷ Richard Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, New York: Free Press, 1977 and Linda Gordon, *Woman's Body, Woman's Right: A Social History of Birth Control in America*, New York, Viking Press, 1976.

fully medicalised condition.²⁸ Beginning with the ground breaking *Your Bodies, Our Selves* (the Boston Women's Health Book Collective, 1971) women's health occupied a central place on the feminist research agenda (Ehrenreich & English 1979; Roberts, 1981; Lewin and Olsen, 1985).²⁹ Citing a number of scholars Davis argues that medical discourse has played an important role in constructing the female body as, by nature, unstable, deficient, diseased and unruly (Bleier, 1984; Keller, 1985; Showalter, 1987; Jordanova, 1989; Scheibinger 1989).³⁰ According to the mind-body dualism in Cartesian thought the female body represents nature, emotionality, irrationality and sensuality. And it always represents the 'other' mysterious, unruly being that 'needed to be tamed and controlled by the (dis)embodied objective male scientist'.³¹ As I have explored women's experiences at the WWCs I think it is pertinent that I touch upon feminist analysis of health, medicine and medical clinic which is an important terrain in feminist studies on the woman's body.

Although Michel Foucault did not analyse women's bodies per se, his identification of the body and sexuality as the direct locus of social control stimulated extensive feminist interest. Foucault identified medicine as a regulatory mechanism which gained ascendancy over other forms of knowledge. He asserted that disciplinary practices adopted by medical clinics objectified bodies (both individual and population) and created productive and docile bodies. When

²⁸ Ann Oakley, *The Captured Womb: A history of the medical care of pregnant women*. Oxford: Basil Blackwell, 1984.

²⁹ Kathy Davis (ed.), *Embodied Practices*, p. 6.

³⁰ Ibid.

³¹ Ibid., p. 5.

medical knowledge about woman's body emerged as a scientific knowledge medical clinic became a place of surveillance where woman's body was effectively regulated, monitored and disciplined. Further Foucault's concepts such as 'discipline', 'docility', 'normalisation' and 'bio-power' were widely studied and developed by feminists of the 1980s with regards to women's bodies.³²

Rejecting the traditional dualistic understanding of power – the ruler and the ruled, the oppressor and the oppressed – Foucault perceived power as a discipline which is constantly exercised through means of surveillance. Feminists such as Sandra Bartky and Susan Bordo developed the concepts of 'self policing' and 'self surveillance' through their studies on disciplinary practices such as dieting, exercise and beauty regimens and eating disorders.³³ Bartky argues that these disciplinary practices subjugate women by generating skills and competencies that depend on the maintenance of a stereotypical form of feminine identity creating them 'self-policing subjects'.³⁴ Developing this idea Bordo argues that these self-policing subjects' subjectivity is maintained not through physical restraint but through individual 'self-surveillance and self-correction' to norms.³⁵ It is not only the medical clinic but also society in general, which works as a policing mechanism towards women's bodies.

³² Susan Bordo, 'Feminism, Foucault and the politics of the body' in Caroline Ramazanoglu (ed.), *Up Against Foucault: Explorations of some tensions between Foucault and Feminism*, Routledge, 1993, p. 193 (pp. 179-202).

³³ Susan Bordo, *Unbearable Weight: Feminism, Western Culture and the Body*, Berkley/Los Angeles/London, University of California Press, 1993.

³⁴ Sandra Lee Bartky, *Femininity and Domination: Studies in the Phenomenology of Oppression*, New York and London, Routledge, 1990, p. 79.

³⁵ Susan Bordo, 'Feminism, Foucault and the politics of the body', p. 191 (pp. 179-202).

Within demographic studies woman's body is studied as a procreative body capable of influencing the population growth rate of a country. By calculating fertility rates, demographers are interested in woman's body for the impact it could make on setting the fertility trends in a country. Development experts perceive the woman's body as a 'reproductive machine', reproducing future labour force. By using the term 'labour' to denote workers as well as the pain that a woman goes through when giving birth to a child Emily Martin argues that medical terms join forces with capitalism by creating a hegemonic understanding of women's bodies as machines of producing future labour force.³⁶ Foucault's concept of 'bio power' succinctly puts all the above-mentioned ideas neatly into a package within a liberal, democratic capitalist society. Foucault coined the term 'bio power' to denote,

a new form of power that emerged in the eighteenth and nineteenth centuries (along with liberalism, democracy and capitalism) through which the state both regularise populations and disciplines individual bodies. Foucault argues that bio power comes into being as the state begins using new technologies and discourses of health, birth, mortality, and demography as mechanisms of regulatory power to exercise control over populations.³⁷

Further Foucault saw bio power as an indispensable element in the development of capitalism, because he argued that capitalism would not have been possible without the controlled insertion of bodies (population) into the machinery of

³⁶ Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*, Boston, Beacon Press, 1987, p. 54–67.

³⁷ <http://pittfemtheorys12.wordpress.com/2012/02/16/biopower-and-the-limitations-of-mainstream-feminist-activism/> (Accessed 20 Oct. 2013).

production (economic processes).³⁸ In fact his concept of bio power talks about a new political right of the capitalist state: 'the power to "make" live and "let" die'; that is, the state's ability to regulate, control and protect populations who are fit to work (productive labour force) by marginalising bodies that are inferior, deviant and threatening.³⁹

A woman's body became a political issue as feminists started to interrogate, analyse and deploy issues on reproductive rights, contraception, abortion rights, sterilisation, domestic violence, mothering theories and reproductive technologies of IVF.⁴⁰ This trend has made the language of "owning" or "controlling" one's body a commonplace within feminist rhetoric.

Scholars studying colonial societies have pointed out that the colonial administration worked towards disciplining the woman's body through the introduction of Christianity and luxury consumer products such as soap, cologne and powder. In order to 'civilise' the 'savage', the colonial administration

³⁸ Paul Rabinow (ed.), *The Foucault, Reader, An Introduction to Foucault's thought*, London, Penguin Books, 1991, p. 263.

³⁹ Michel Foucault, *"Society Must Be Defended": Lectures at the College de France, 1975-76*, edited by Mauro Bertani and Alessandro Fontana (New York, 2003), p. 241.

⁴⁰ See Jana Sawicki, *Disciplining Foucault: Feminism, Power and the Body*, New York, London, Routledge, 1991, Gene Corea, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*, New York: Harper & Row, 1985, Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of Expert's Advice to Women*, London: Pluto Press, 1979, Gordon, *Woman's Body, Woman's Right*, 1976, Dorothy Roberts, *Killing the Black Body, Race Reproduction and the meaning of Liberty*, New York, Pantheon Books, 1997, Rosalind Petchesky, *Abortion & Woman's Choice*, New York: Longman Press, 1984, Claudia Dreifus, *Seizing our Bodies*, New York: Vintage books, 1978, Michelle Stanworth (ed.), *Reproductive Technologies: Gender, Motherhood and Medicine*, Cambridge, Polity Press, 1987, M. McNeil et al. (eds), *The New Reproductive Technologies*, London, MacMillan, 1990 and Jose Van Dyck, *Manufacturing Babies and Public Consent: Debating the New Reproductive Technologies*, London, MacMillan, 1995. Charo, R.A., 'Problems in commercialised surrogate mothering', *Women & Health*, 13:1:2(1987), pp. 195-201, and Corea G., 'The Reproductive Brothel,' in G. Corea, R.D. Klein, et. al. (eds), *Man-Made Women: How New Reproductive Technologies Affect Women*, Bloomington: Indiana University Press, 1987, pp. 33-51. Ginsburg & Rapp, p. 315

introduced public health through Western medicine, and education through missionary schools.⁴¹

Moving our analytic gaze to South Asia's past, analysing independence movements and nationalist movements in South Asia, feminists have shown how the state deployed women's bodies to foster a national identity among its people, and also to maintain its position as a patriarchal father figure.⁴² In her insightful analysis about the recovery process of abducted women of India and Pakistan after Partition in 1947, Ritu Menon pointed out that the state's responsibility towards its citizens was embedded in discourses of nationalism, honour and manhood. Further, she argued that the recovery of women's bodies was significant, as they represented national identity and also demarcated boundaries between and within communities, genders and nations for three reasons. Firstly, because they were transgressed by abduction and the 'honour' of the nation is compromised. Secondly, women's forcible conversion became a religious issue. Thirdly, because they have cohabited with men from the other nation, the legitimacy of the children born from such 'wrong' unions was seen as a threat to the purity of the family, community and ultimately the nation.⁴³

⁴¹ See Partha Chatterjee (1993), Anne McClintock (1995), Chandra Mohanty (1991), Kumari Jayawardene, (1986), Malathi de Alwis (1996, 1997, 2004) , Kumari Jayawardene and Malathi de Alwis (1996), Neloufer de Mel (2004, 2007), Sitralega Maunaguru (1995) and Qadri Ismail (1995) and A. Stoler (1989).

⁴² See Kumkum Sangari (1990), Floya Antias and Nira Yuval-Davis (1992).

⁴³ Ritu Menon, 'Reproducing the Legitimate Community: Secularity, Sexuality and the State in Postpartition India,' in Patricia Jefferey and Amrita Basu (eds), *Appropriating Gender: Women's Activism and Politicized Religion in South Asia*, New York, London, Routledge, 1998, p. 18., (pp. 15–32).

The common theme that runs through all these studies and disciplines is that women's bodies are deployed (across space and time) and disciplined, in one way or the other, to service the family, the economy, the nation and the state. Consequently, much of feminist research has concluded that women are deprived of autonomy and rights over their bodies. Disregarding Chinese women's opinion on the oppressive nature of the one-child family policy and Indian women's opinion on abusive population control practices during the emergency of 1977, regulation of reproductive practices has become a form of social surveillance today.

In the next section I will show how these larger debates on women's bodies at the global level have reflected scholarship on the woman's body in Sri Lanka. After the experience of Western colonial domination for four centuries (1505–1948), Sri Lanka went through processes of nationalism, nation building and state building. Discourses on women's bodies came up as categories of analysis in all these processes. The following section gives an overview of scholarship on the woman's body in Sri Lanka from colonial times to the present in order to show how and why discourses on woman's body and women's health in Sri Lanka did not cross each others' paths.

Scholarship on the Woman's Body in Sri Lanka up until Now

Studies on Sri Lankan women's sexuality, her their maternal, social and cultural reproductive bodies have been done by eminent scholars such as Kumari

Jayawardene (1993, 2000, 2003), Swarna Jayaweera (2002), Malathi de Alwis (1996, 1997, 2004), Neloufer de Mel (2004, 2007), Neluka Silva (2002, 2004) Radhika Coomaraswamy (2003) and Sitralega Maunaguru (1995). The main focus of these works was on the history and development of the women's movement in Sri Lanka, women's education and its connection to social mobility, political participation, and social change. Women's health did not come up as a category of analysis in any of these works.

A related body of work has investigated the relationship between the maternal body and the militarised body in relation to issues of nation building and ethnicity. De Alwis (2004), Coomaraswamy (2003) and De Mel (2004) have engaged with depictions of the Sri Lankan women's bodies in political and conflict settings, where they were forced to depart from traditional attire and behaviour and adopt completely different, untraditional roles. These studies asked: What is this so-called traditional role and how was it constructed for a particularly Sri Lankan context?

In this thesis, I concentrate on Sinhalese Buddhist nationalism which took shape in late nineteenth century in order to map how the woman's body became a marker of identity in the nationalist project of colonial and post-colonial Sri Lanka. Although Tamil nationalist projects also framed woman's body in a particular way at different moments in the past, in this dissertation I do not deal with the Tamil case in detail. This is because Sinhalese Buddhist nationalism is the

dominant discourse in state building and nation building of post independent Sri Lanka.⁴⁴

The initial nationalist ideology (which was heavily influenced by India) in the late 1800s was a reaction to British colonial power: trying to define or “imagine” what is Ceylonese in relation to the ruling power. It was a moment of defining Ceylonese for Ceylon. Within this discourse women’s position and role in Sinhalese Buddhist nationalist discourse was defined mainly by Anagarika Dharmapala, one of the leading nationalists of the day, and was also heavily influenced by the Theosophical Society during the late 1800s (British colonial period).⁴⁵ Dharmapala made a great impact on the lives of the rising Sinhalese middle class in the early twentieth century. The adoption of Western manners, etiquette and dress by the new middle class was severely criticised by Dharmapala who introduced a new Sinhalese life-style in which he bestowed women with a special and rather active role within the domestic sphere. He published a pamphlet, the *Daily Code for the Laity* (In Sinhala *Gihi Dinacharyawa*), in 1891, as an attempt to ‘civilise’ the emerging Sinhalese middle class.⁴⁶ Seneviratna saw Dharmapala’s attempt as a combination of Buddhist and Christian values and termed it ‘Buddhist modernism’ or ‘Neo-Buddhism’, an ideal that lay emphasis on

⁴⁴ This is an area I would like to explore in the future.

⁴⁵ Valisingha Harischandra, S. Mahinda Thero of Tibet and Henry Steel Olcott to name a few of the nationalists of the day.

⁴⁶ It provided detailed advice for the laity on general etiquette and dress. Lay people were given instructions under twenty-two headings such as, how to behave during meals, how to travel in public transportation, on wearing clean clothes, and good toilet habits etc. Out of these, thirty rules were laid down on how women should behave and their duties towards the family. In general these rules give a clear picture of Dharmapala’s intention of social reform; he touches upon all the aspects of the laity’s life. By 1958, 49,500 copies of the pamphlet were sold.

punctuality and thriftiness in the hope of gearing the Sinhalese middle class to take up the modern nation-state-building project.⁴⁷

In the *Daily Code for the Laity*, women were advised to maintain a clean, orderly house and to attend to all housekeeping and child rearing duties. The middle class mother was endowed with holy status within Buddhist revivalist ideology—she was proclaimed the ‘Buddha at home’ (*Gedara Budun*). Through this newly bestowed respect, her body and sexuality became carefully disciplined and made docile in order to fulfil the social reproductive role of bringing up moral and cultured children who would be the future of Mother Lanka. He emphasised the parental responsibility in the nuclear family unit (a new phenomenon in the colonial period as opposed to the agricultural extended family) where mothers played the role of the teacher at home, cultivating social and moral values in their children, while fathers played a social role in society by providing for the family.⁴⁸

According to Neloufer de Mel, the

[n]ationalist discourse constructs a division of gender which renders the male as the author and subject of the nation, while the female stands for the nation itself, in need of male protection, the reproducer and nurturer of future generations and transmitter of cultural values. As reproducer she carries the responsibility of avoiding miscegenation to ensure ethnic, class, caste or racial “purity”. Her sexuality has to be policed and regulated to this end in the service of the nation.⁴⁹

⁴⁷ H. L. Seneviratne, *The Work of Kings-The New Buddhism in Sri Lanka*, University of Chicago Press, 1999, p. 24–26.

⁴⁸ Chatterjee makes this point quite succinctly on Indian nationalism in his seminal work *The Nation and its Fragments: Colonial and Postcolonial Histories*, Princeton, Princeton University Press, 1993.

⁴⁹ Neloufer de Mel, *Women and The Nation's Narrative: Gender and Nationalism in Twentieth Century Sri Lanka*, Lanham, Boulder, New York, Rowman & Littlefield Publishers, Inc., 2001, p. 2–3.

The entire attitude towards the family transformed with the new social and moral obligations bestowed upon the middle class woman. Of course this new middle class woman became the model to emulate by those with lower educational and social background.

De Alwis reminds us how Dharmapala constructed the appearance of the ideal Sinhalese Buddhist woman by introducing respectable attire for her: 'a six yard long preferably white, *saree* or *hori* (later referred to as *osariya*).'⁵⁰ He also specified that the saree jacket should 'completely cover the breasts, midriff, navel and back.'⁵¹ In designing a national dress for women, Dharmapala's aim was not only to create a new identity for the Sinhalese middle class, but also to control the woman's body by deciding the extent to which it can be revealed. On the one hand, her body was given a marker of identity, and, on the other hand, her movements were restricted by the assignment of specific domestic duties. She was bestowed with the dual role of social and biological reproduction. Within Dharmapala's nationalist project women's sexuality and bodily movements were vigilantly controlled in the name of moral ethics. De Alwis provides an insightful analysis to the embodiment of the woman's body during the colonial period through her study of the Sinhalese cultural practice *lajja-baya* (shame and fear).⁵² She uses the notion of 'respectability', an amalgam of both Christian and

⁵⁰ Malathi de Alwis "Respectability', 'Modernity' and the Policing of 'Culture' in colonial Ceylon' in Antoinette Burton (ed.), *Gender, Sexuality and Colonial Modernities*, London/NY, Routledge, 1999, p. 181.

⁵¹ W.A.P. Guruge, (ed.), *Dharmapala Lipi*. Colombo: Government Press, 1963, p. 85. .

⁵² De Alwis "Respectability', 'Modernity' and the Policing, p. 177-192.

indigenous notions of morality, to provide insights into the new Sinhalese culture through which the bourgeois woman's body was regulated and disciplined.

Apart from identity creation through attire, de Alwis observes the role played by the colonial state in regulating women's bodies through formal education. Missionary education, especially in boarding schools, disciplined and moulded the careless, restless bodies and the inattentive, obstinate minds of native girls.⁵³ Women's education, first introduced in missionary schools and later in national schools established by the Theosophical Society in Sri Lanka, was a progressive step towards women's emancipation. Despite being dated, Dharmapala's concepts such as '*Gedara Budun*' are still taught in the school curriculum of Sri Lanka. Contesting the notion of emancipation, Jayawardena argued that women's education perpetuated and reproduced patriarchal ideology by limiting women's curriculum to needlework, home economics, cookery, drawing and piano music.⁵⁴ The general perception was that 'girls needed only limited education, just enough to make them presentable house wives.'⁵⁵ Even though female literacy rate in Sri Lanka is a commendable 97 percent today,⁵⁶ as Jayawardene pointed out, women are still educated within an ideological

⁵³ Ibid., p. 179. Also see Malathi de Alwis, 'Motherhood as a Space of Protest: women's political Participation in Contemporary Sri Lanka,' in Amrita Basu and Patricia Jeffrey (eds), *Appropriating Gender: Women's Activism and the Politicization of Religion in South Asia*, London/NY: Routledge, Delhi: Kali for Women, 1997, for further analysis on how women's bodies were disciplined and made docile through missionary education in Sri Lanka.

⁵⁴ Kumari Jayawardene, *Feminism and Nationalism in the Third World*. London/New Jersey: Zed Books Ltd, 2003, p. 120.

⁵⁵ Ibid. See also Swarna Jayaweera, 'Women and Education,' in Swarna Jayaweera (ed.), *The UN Decade for Women: Progress and Achievements of Women in Sri Lanka*, Colombo, CENWOR, 1989, and Swarna Jayaweera (ed.), *Women in Post-Independence Sri Lanka*, New Delhi/London, Sage, 2002.

⁵⁶ <http://www.accu.or.jp/litdbase/policy/lka/index.htm> (Accessed on the 9th Mar 2012).

framework of patriarchy. Then what do these excellent female literacy statistics obfuscate? Since women's education is more geared towards producing presentable housewives, to fulfil a necessarily social reproductive role, education does not equip women with essential tools to think 'beyond' this reproductive role that they are traditionally bestowed with. In fact female education in Sri Lanka has become a double-edged sword. On the one hand, female literacy rate is high when compared to other countries of the region, which is the most crucial determinant to measure women's empowerment. On the other hand, women's education has a strong emphasis on social reproduction. The empowerment that women are supposed to achieve through education is entangled with the aim of training for social reproduction, thus depriving women of reproductive rights. This problem lies at the root of my interrogation of the women's health 'success story' of Sri Lanka.

Radhika Coomaraswamy, Neloufer de Mel and Adel Balasingham have explored a new category of women during the conflict – the Liberation of Tamil Tigers Eelam (LTTE) women cadre - and their role. Analysing how the notions of women's emancipation and their reproductive role were deployed by the Tamil militant group Coomaraswamy questions whether the enrolment of women to the ranks of the LTTE meant women's emancipation or the strengthening the organisation. Neloufer de Mel argues that the female body has been used by the LTTE to achieve its political agenda by training women to be suicide bombers. This act that could be characterised as unfeminine was justified within traditional

lines as, by the argument that women were thus protecting their motherland for the future children of the nation. In response to this, Malathi de Alwis explores the state discourse on the moral oriental mother; despite the violence it connotes in order to fulfil the political agendas of the state.

Another set of scholars, Selvi Thiruchandran (1999), Sepali Kottegoda (2004), Caitrin Lynch (2007) and Sandya Hewamanne (2008), have attempted to understand another set of new categories of womanhood that emerged with the opening up of the economy in 1977 and the ethnic conflict of 1983. The new categories include female factory workers in Free Trade Zones (FTZs), female migrant domestic workers in the Gulf, and female headed households due to Sri Lanka's protracted ethnic conflict. Despite the centrality of women's bodies and sexuality—and by extension their health—to these topics, women's health appeared rarely if at all as a subject of analysis in the works of these scholars.

From the discussion above, it is clear that the 'women's health' discourse in Sri Lanka is predominantly a territory confined to policy makers, medical professionals, demographers and economists. In contrast, the discourses on the 'woman's body' seem to be a territory largely confined to attentions of feminist social scientists. Thus, the above mentioned studies are not as helpful as I had hoped in critically addressing my question about Sri Lanka's women's health 'success story'. Very few have dared to trespass the epistemic and disciplinary boundaries between discourses on 'women's health' and the 'woman's body'. Broadly speaking, 'woman's body' is a subjugated discourse within women's health

discourse of modern Sri Lanka. As women's health indicators were crucial in building up the "success story", discourses on the woman's body and its role in women's health were neglected. Because of this subjugation, women are essentially denied the right to their bodies in women's health discourse of modern Sri Lanka. By subjugation, I do not mean that women are forcefully denied the right to their bodies, but that the woman's body is neatly packaged into a form of social surveillance in the modern welfare state of Sri Lanka. This surveillance is essentially a product of twentieth century global discourses on population control, development and modernity that I have already discussed above. Like other Third World countries, Sri Lanka could not escape this surveillance process.

By transgressing these disciplinary boundaries, I will show how women's bodies continue to serve as referents and targets of women's health programmes. I strive to use the data produced out of a women's health discursive framework. Simultaneously, I bring insights from a range of lively provocations provided by scholarship on women's bodies in Sri Lanka.

Methodology

My research methodology consisted of an admixture of archival research, critical reading of published sources and in-depth interviews. My thesis attempts to challenge the women's health 'success story' of modern Sri Lanka through the mobilisation of discourses of the woman's body and looking at women's corporeal experiences. Thus my research demanded multiple methods of analysis. As

mentioned above, women's health and women's health discourse has come to denote institutions, statistics and state building, while research on women's bodies and discourse on the woman's body deal with culture, religion and nation building. I engaged in archival research and the critical reading of published sources to deal with the institutional, women's health component of the research. The woman's body component was mainly dealt with by conducting in-depth interviews.

As I conducted my archival work and field work at a number of different geographical sites, I did so in a contrapuntal manner. That is, I spent the first three months reading documents at various archives and libraries, and then the next three months engaging in field work conducting interviews. The change of field sites gave me space not only to contemplate and interrogate new categories and issues, but also made me realise how I trespassed into the epistemic provinces of the sociologist and the anthropologist. To access these research materials, I assumed different roles according to the setting.

The research process was a challenging experience, particularly when I had to face medical professionals and demographers of Sri Lanka who challenged my methodology, in shock that a historian might dare to probe into their 'scientific episteme'.⁵⁷ Even though women's health is centred around issues of population growth rate for the medical professionals and demographers of Sri Lanka, for me (a historian) women's health extended beyond reproduction to reproductive health

⁵⁷ I have footnoted some of these experiences in chapters 2 and 5 and provided an analysis to these interviews with medical professionals.

and rights, discourses on the woman's body and women's corporeal experiences. That is why I could not limit my research to the traditional site of the historian—the archives. I had to conduct interviews with people from different strata of society. This seemed quite an unusual practice for a historian to many of my interviewees, and the history of medicine is a discipline simply unheard of in Sri Lanka.

Considering the wide variety of data that I have collected during the research process, it is important to provide a brief introduction to the various research sites and the types of data collected from each site in the next section. The section that follows will also provide an analysis of my identity and position during the research process and of the ethical issues and challenges that I faced.

Archival Research

I have conducted archival research in three countries, namely in Sri Lanka (from July 2009 to August 2010), the UK (September 2010 to December 2011) and the US (August to September 2011).

I have consulted primary sources such as census reports at the Department of Census and Statistics in Colombo Sri Lanka, development plans of independent Sri Lanka at the Ministry of Finance and Planning in Colombo, annual reports of the Family Planning Association (FPA), the Population and Reproductive Health Policy of 1998 at the FPA, Colombo, annual reports of the Family Health Bureau (FHB) and policies, circulars and handbook on Island wide Well Woman Clinic

(WWC) programme at the FHB, Colombo, and Sinhala and English newspapers at the National Archives of Sri Lanka and at the National Library Services Board of Sri Lanka in Colombo.⁵⁸

I consulted Dr Siva Chinnatamby's correspondence with such pioneers of contraceptive research as Dr Gregory Pincus of the Worcester Foundation in Boston and Clarence Gamble in New York, the national pharmaceutical policy at the Library of Congress in Washington DC, the Rockefeller Archives in New York and the Countway Medical Library in Boston. As none of Chinnatamby's private papers were available in Sri Lanka (either at the National Archives or the FPA resource centre where she served as the medical director from 1953 to 1978) I went to the US to consult them.⁵⁹ By introducing the Pill to Ceylon in 1961, Chinnatamby became not only a modern development idol to the medical professionals of Sri Lanka, but a scheming unmarried woman of the minority Tamil ethnic community trying to make the majority extinct to Sinhalese Buddhist extremists. Due to her dual identity, it seemed essential for my research that I unravel her correspondence with Pincus and other key players of the global contraceptive debate. I approached these correspondences more in the manner of a detective investigation than an archival research of a traditional historian.

⁵⁸ Newspapers of the pre-1977 period are deposited at the National Archives in Colombo while newspapers of post-1977 to date are deposited at the National Library Services Board in Colombo, Sri Lanka.

⁵⁹ There was no particular interest to build an institutional memory at the inception of the FPA. Even though the resource centre was established in the late 1990s, the resource centre manager informed me that those piles of old documents were destroyed when the centre was flooded twice during the last decade. Further, Chinnatamby's successor at the FPA also told me that Chinnatamby's personal correspondence and diaries were not preserved anywhere in Sri Lanka, so I tried to trace them at the other end in the US.

These correspondences provided a window into the understanding of the politics of contraception both at the global and the national level. Furthermore, they elucidated on Ceylon's entry into the global pill trials as a laboratory site, the discussion that this prompted on contraception, the moral values around women's bodies and ethnicity. I used newspaper articles and advertisements of the Pill published in English and Sinhalese to explore subjugated discourses of ethnic forces (*vanda beheth/pethi*, pills of sterility) and market forces (*Mithuri*, female friend) in the late 1960s and 1970s.

At the Wellcome Library in London, I went through various reports of the Conference on Birth Control in Asia organised by the London School of Hygiene and Tropical Medicine. Further, my reading of secondary sources on population, development and politics of global family planning in the UK helped me contextualise the women's health discourse in independent Sri Lanka within broader discourses of population, development and modernity.

Field Research

As mentioned above, my methodology comprised of both archival and field research. I conducted oral history interviews and in-depth interviews with people from different strata of society so I used pseudonyms to protect the identity of those respondents who are recipients of public health policy.

Interviews that I carried out can be categorised mainly into two sub groups. The first category can be identified as women's health policy makers. I have

conducted interviews with retired policy makers, implementers of population policy, members of staff at the Medical Faculty of the University of Colombo and retired women teachers of public schools.⁶⁰ I tapped into their memory by conducting oral history interviews with them, because I was keen to know how population policy measures and their implementation were conceptualised in Sri Lanka especially in the 1970s and 1980s. As Portelli advises, I use oral histories to tell about the ‘meaning of the event’ not ‘about the event’, because it reveals unknown aspects of a known event.⁶¹ These interviews supplemented and at times elaborated my archival findings. Living memories were also helpful to understand the ‘controlling and planning’ mind-set of health policy makers and bureaucrats of Sri Lanka and the ‘cult of population control’ embedded in the official rhetoric of women’s health in Sri Lanka.⁶²

The second category of informants can be identified as recipients of women’s health policy. Considering how the state deployed women’s bodies in implementing population policy measures in Sri Lanka I have conducted in-depth interviews with five Free Trade Zone (FTZ) workers, five housemaids returned from the Middle East and ten Well Woman Clinic (WWC) attendees at the

⁶⁰ See Appendix for all the interviews that I conducted and biographical notes on some key informants.

⁶¹ Alessandro Portelli, ‘What Makes Oral History Different,’ in Robert Perks and Alistair Thomson (eds), *The Oral History Reader* (Second Edition), (London and New York: Routledge, 2006), p. 36 (pp. 32–42).

⁶² Betsy Hartmann, *Reproductive Rights and Wrongs, The Global Politics of Population Control*, Boston, South End Press, 1987, p. 104. Hartman uses the phrase the ‘cult of population control’ to analyse how everybody from policy makers to policy recipients at the grass roots level believes in development through population control. I find this an ideal phrase to use about the mind-set of the population policy makers of independent Sri Lanka.

Dehiwala Medical Officer of Health (MOH) area (the most attended WWC in Sri Lanka). All these groups of women bear a distinct relationship to my thesis. Free Trade Zone workers and migrant housemaids were a product of the open market economy that Sri Lanka adopted in the late 1970s. Both FTZ workers and migrant women occupy a distinct and privileged status within contemporary state policies and the social milieu of Sri Lanka.⁶³ Even though these women are marginal in body politic, they are central to the national economy. Given the importance of their labour, the state takes measures to monitor their reproductive bodies, *but not their health*. Through conducting in-depth interviews with these women, I explored how the state mobilised discourses of ‘patriarchy’ and ‘motherhood’ to discipline women’s reproductive bodies. By doing so, the state continued to frame women’s bodies within social reproductive role as docile girls in the FTZs and responsible mothers in the Gulf.

The in-depth interviews with WWC attendees address a slightly different issue in my research. They helped me explore how the shift from family planning to reproductive health and rights advocated by the ICPD in 1994 was translated at the grassroots level through the WWC programme—the consequence of the new discursive formation of ‘beyond reproduction’.

⁶³ See studies of Sandya Hewamanna, *Stitching Identities in a Free Trade Zone: Gender and Politics in Sri Lanka*, Pennsylvania, University of Pennsylvania Press, 2007; and Gamburd, M.R., *The Kitchen Spoon’s Handle: Transnationalism and Sri Lanka’s Migrant Housemaids*, New York, Cornell University Press, 2000.

Positioning Myself and Ethics

When doing research at a number of research sites and geographies, I realised that I had to assume different identities and positions suited to the situation. Anthropologists have widely debated about the researcher's position – subjective insider and the objective outsider – that he/she has to acquire during data gathering.⁶⁴ Drawing on these methodological debates, this section deals with how I identified and positioned myself at the different research sites and how I related to the research ethics involved in the process.

By the 1970s and 1980s, influenced by Foucault's writings and the post-modern movement, anthropologists started to pay attention to the power dynamics and the knowledge construction involved in field work. Anthropologists started asking themselves if it was possible to objectively study a culture when their own biases and epistemologies were inherently involved in the process. This resulted in a 'reflexive turn' in anthropology.⁶⁵ Throughout my research I remained self-conscious and carried on self-critique. By doing so I acquired multidimensional identities. Similar to Visweswaran's argument, I also had to choose different identities according to the nature of the situation I found myself in.⁶⁶ By having multiple identities I did not commit any dishonesty. My approach to having multiple identities can be summed up by the Sinhala proverb as '*théne*

⁶⁴ See A.C.G. M. Robben and J.A. Sluka (eds), *Ethnographic Field Work: An Anthropological Reader*, Wiley Blackwell Publishers, 2007 and Raymond Madden, *Being Ethnographic: A Guide to the Theory and Practice of Ethnography*, Newbury Park, Sage, 2010.

⁶⁵ See J. Spencer, 'Ethnography after Postmodernism' in P. Atkinson, Al Coffey et al., (eds), *Handbook of Ethnography*, London: Sage, 2001 and Sluka and Robben, *Ethnographic Field Work*, 2007.

⁶⁶ K. Visweswaran, *Fictions of Feminist Ethnography*, Delhi: Oxford University Press, 1996, p. 8.

hatiyata ane gahanawa ('to nail according to the place', implying to act according to the situation).

Interviewing Women's Health Policy Makers

I tried my best to position myself as an 'insider' when conducting interviews with health policy makers and implementers in order to understand how policy makers perceived the link between women's health, population and development. But soon I realised that it was very hard for them to recognise me as an 'insider'. Health policy makers and implementers bore a disrespectful, bewildered attitude towards me, a historian, for researching a theme so far considered exclusive to the domain of medical, health and demographic research. Since, for them I was not researching anything a historian should, I was trespassing. However, I was well aware that my position as a Warwick PhD student should elevate my status as a researcher in light of the colonial legacy. All the above mentioned women's health policy makers and implementers had a reverence for a student of a British institution. Using a multidimensional identity suggested by Visweswaran, I deployed my Warwick PhD student identity when interviewing health policy makers.⁶⁷ Maintaining the Warwick PhD identity meant that I had to take the greatest care of my attire, language and the way I present myself. I dressed up

⁶⁷ Ibid.

smart, leaving behind my comfortable long *kurtha* tops and pants,⁶⁸ And I took great care not to mispronounce English words during my interviews with them. In this way, I managed to appear somewhat an ‘insider’ to them. However, I could not help feeling the air of authority that academics of medicine assumed over non-medical academics; I was made to wait outside their office to meet them and they made me feel their superiority during the interview process. The interviews were conducted mainly in English but my respondents used Sinhalese intermittently, especially when talking about and repeating slogans of the family planning programme.

Complying with social norms, I positioned myself as a submissive research student when conducting interviews with retired school teachers. I addressed them with reverence and greeted them with veneration.⁶⁹ They shared their experiences and reminiscences about teaching reproductive health in schools in the 1970s and 1980s. Finding retired teachers to interview turned out to be a challenge as most of them had migrated abroad to live with their children or were not healthy enough to participate in the research. I first approached my father-in-law’s retired friends from the government training college and then the teachers of my closest friends.⁷⁰ I interviewed six teachers out of which five were in

⁶⁸ There is a significant difference between the attire of a medical student and any other faculty student in University of Colombo. Medical students’ attire is very smart while students of other disciplines adhere to a more comfortable dress code.

⁶⁹ In Sri Lankan schools, students greet their teachers by paying obeisance and calling them ‘madam’ or ‘sir’ and not by their surname.

⁷⁰ Due to the distance between the teacher and student in school, I decided not to approach my own school teachers, as they would find it difficult to talk to me about reproductive practices that

Sinhalese and one in English. These interviews lasted between two to four hours. On prior appointment, I interviewed four of them at their houses and two after classes they conducted in an orphanage as voluntary service in Wellawatte, Colombo 4.

I took the position of a feminist—researching on, by and for women—when interviewing recipients of women’s health policies in order to make space for them to voice what they feel.⁷¹ Unlike policy makers and implementers, policy recipients bestowed me with authority due to my educational, social and economic status. This created a clear division between me, the researcher, and them, the narrators. But as a true feminist, I did my best to convince them that I do not know anything about their experiences and they are the knowers in my research *not me*. I tried not to label myself as a researcher in the traditional academic sense. As Yaw suggested, I tried to change the researcher–narrator relation into two people sharing their knowledge in a process of discovery by relating my own caesarean experiences and various tests at the WWC such as Pap smear test.⁷² This approach helped to bridge that gap between the researcher (me) and narrators (them). I found that the best way was to simply be a human being bearing sensitivity and empathy towards the narrators and their social and personal

were prevalent in their youth, how they taught the topic in school, and the responses they received from students.

⁷¹ See Sandra Harding (ed), *Feminism and Methodology*, Bloomington: Indiana University Press, 1987, J. M. Neilsen, *Feminist Research Methods: exemplary readings in the social sciences*, Westview Press, 1990 and Judith Stacey, ‘Can there be a feminist Ethnography’ in Sherna B. Gluck and Daphne Patai (eds.), *Women’s Words*, New York: Routledge (pp. 111-19), 1991 discussing about taking a feminist position in field work.

⁷² Valerie Yow, ‘Ethics and Interpersonal Relationships in Oral History Research’ in *Oral History Review*, Vol. 22, No. 1 (Summer, 1995), p. 53, (pp. 51-66).

experiences. I spent four months in the field interviewing five FTZ workers, five migrant women and ten WWC attendees, and I visited them at least four times during my field work.

Drawing on methodological debates on exploring feminist oral histories the next section deals with how I conducted the interviews and coped with ethical issues involved in the interaction with women's health policy recipients.

Interviewing Women's Health Policy Recipients

Due to my previous research experiences, I already knew some FTZ workers who were willing to participate in the interviews. I reached the Gulf-returned migrant women mainly through the use of snowball sampling method. I started with my friends' domestic help, who put me in touch with their friends who were willing to share their experiences with me. During my MA research I conducted interviews with thirty WWC attendees at two WWCs (Attidiya and Kotalawalapura) in the Dehiwala MOH area (the most attended WWC). I contacted the same Public Health Nursing Sister at the Dehiwala MOH office regarding my PhD research. After acquiring formal permission to conduct interviews, I decided on the same two WWCs at Attidiya and Kotalawalapura, because I already had established acquaintances with them. It was essential to have a good rapport, as I was questioning women on their bodily experiences of health policy implementation through the public health system of Sri Lanka. As a married female researcher who grew up in Sri Lanka, I was well aware of the

patriarchal power structure of the society in general and of the medical and health sector in particular. Without knowledge of such fundamental truths about a society, it is not easy to research into women's corporeal experiences.

i) Interviewing FTZ Workers

FTZ workers and migrant women are the most exploited groups of women by researchers, as they are the products and victims of the global capitalist economy that Sri Lanka opened itself up to in 1977. Their corporeal experiences are a rich source of data for my research because of their marginal position in the health sector of the welfare state of Sri Lanka.

First, I conducted ten interviews out of which I selected five informants to conduct in-depth interviews. The in-depth interviews were unstructured and conducted in a casual conversational manner. All these interviews were conducted at workers' boarding houses in Katunayake during weekends. All my informants were single, Sinhalese Buddhist girls from rural areas between the ages of 20 to 28. These in-depth interviews were conducted in Sinhalese and lasted around two hours. When visiting them in their boarding houses I took some provisions such as a packet of milk powder, tea leaves and sugar to comply with the cultural practices of society.

As a responsible researcher, I could not help feeling guilty for exploiting them by using their leisure time for the interviews. Of course, feminist scholars across social science disciplines such as Herbert C. Kelman (1977), Ann Oakley

(1981), Stacey (1991) and Valerie Yaw (1995) to name a few, have questioned the possibility of exploitation of researched persons.⁷³ As suggested by Oakley, I tried to form more equal and open relationships without being detached for the purpose of researching objectively. I tried to minimise the unequal power relationship between FTZ workers and me by conversing with them in a casual manner while they were washing clothes by the well or cooking lunch in the kitchen.

ii) Interviewing Migrant Workers in the Gulf

Out of the ten migrant workers that I interviewed through snowball sampling, I selected five of them to conduct in-depth interviews. I gave them two options; I invited them to my place or I offered to come and conduct the interview at their place. Out of the five migrant workers, two preferred to come to my place for the interview, the rest I conducted at the informants' houses. All these interviews were conducted in Sinhalese and they lasted about two to three hours. According to their preference, I chose the morning hours after they sent their children to school and husbands to work. When I visited them at their houses I took some provisions just like for the FTZ workers. Out of the five Gulf-returnees, two took half a day's leave several times from their current workplaces to take part in the interviews, which, I am afraid, I had no way of compensating. When I asked them why they did that, they said that they did it with pleasure and for a greater cause.

⁷³ See for example Valerie Yow, 'Ethics and Interpersonal Relationships' 53; Herbert C. Kelman, 'Privacy and Research With Human Beings,' in *Journal of Social Issues* 33 (1977), 169–95. Ann Oakley, 'Interviewing Women: A Contradiction in Terms,' *Doing Feminist Research*, in Helen Roberts (ed.), New York: Routledge, 1981, pp. 30–61.

In a country where education is highly valued, by giving me time for an interview, they were helping a student achieve her educational goals. The female migrant workers I interviewed were between the ages 28 and 46, all married with children.

Both FTZ workers and migrant women expressed their views on their bodies very frankly. As Van Hollen points out, women express themselves quite openly to female researchers, because they feel they are talking to someone who understands them, since all share common experiences as women.⁷⁴ Since both these categories of women were studied by sociologists, feminists and anthropologists quite frequently, they were familiar with structured interviews and questioning involving filling in boxes on survey questionnaires, so I took great care to make them reflect upon their bodies, which is not a question that they usually face. When they realised that I am not interested in one word answers and I am determined to spend time with them and listen to them, they felt relaxed to answer my questions about their bodies and health concerns.

iii) Interviewing WWC Attendees

As mentioned above, I approached WWC attendees through connections already established during my MA research. First, I paid a casual visit to the most willing fifteen women whom I selected from my MA notes, then selected ten based on the rapport I had with them and on their availability. I interviewed them at their houses during morning hours (between 9.00am and 1.00pm), where I found them

⁷⁴ Van Hollen (2003) has noted the same open enthusiasm during her research on birthing practices in the village of Kaanathur-Reddikuppam in Madras, Tamil Nadu.

attending to household chores at their own pace. These women were between the ages of 35 to 44, married with children. I conducted the interviews in Sinhalese in a narrative style, and focused particularly on their attitude towards hygiene, child care, illness and preventive health care. Adopting a narrative style helped women liberate their previously unspoken voices regarding their bodies. In my view this is crucial in Sri Lanka, since there is no space for women to voice their thoughts about their bodies especially in medical research. As Burns and Walker point out, by interviewing them as a feminist researcher, I challenged the 'silencing of women's voices in society and research.'⁷⁵ Further, by giving them a space to talk about their bodily concerns, I challenged the narrow, gendered way in which medical research is conducted in Sri Lanka by casting women as passive and subordinate subjects. Thus I consider my research a contribution to the feminist perspective on the woman's body in Sri Lanka.

When I went to my informants' houses, they always welcomed me with a smile and spoke to me for hours about their experience at WWCs, their knowledge on cancer, their perception of other illnesses and their household responsibilities as mothers and wives. Though the topic I explored is sensitive and private, these women responded willingly, because the respondents felt that there is a common experience that we all share about our bodies as women, which a male researcher or a doctor would never understand.

⁷⁵ Diane Burns and Melanie Walker, 'Feminist Methodologies,' in Bridget Somekh and Cathy Lewin (eds), *Research Methods in the Social Sciences*, London, Sage, 2005, p.66, (pp. 66–73).

One may ask if it is ethical for me to discuss with women how they feel and understand their bodies. I believe, if women are happy to express these feelings, why not listen and talk and share their experience through research? Unlike in Western or even Sri Lankan upper middle class cultures, these women are quite expressive and open about their lives and feelings. For example, Lalani discussed with me her worry over her 23 year old daughter's marriage, since Lalani has made her daughter break the affair that she started at school, and encouraged her daughter to go out with another, well-to-do young man. Now the daughter is not very keen to get married and settle down.

Instead of being a passive listener as prescribed in traditional methodology textbooks, I was fully engaged in these conversations, responding to their various queries, anxieties and worries.⁷⁶ This helped me build my informants' confidence in me. Also being a mother, I felt it was not ethical for me to evade questions posed to me with great expectations, such as how to deal with a new-comer in the family, how to manage time to spend on the elder child, and how to control tempers that get stirred up with a new addition to the family. So I exchanged what I knew, what I have experienced and what I had read about handling these situations. This, I believe, helped them see me not just as a researcher who wants to extract information about their lives in order to fulfil her academic objective, but as a genuine person with a sense of responsibility towards them.

⁷⁶ Oakley (1981) discusses methodological problems with textbook 'recipes' of the art of interviewing.

My research in Dehiwala was supplemented by my own body check-up at a WWC set in a private hospital in Colombo, in order to experience what women go through when undergoing tests at WWCs. Similar to what happens in WWCs set up at MCH clinics, I was not explained by the lady doctor at the private hospital about the Pap smear test, but she assured me that it will not be painful. I found my experience at the WWC very useful during the long conversations with my respondents.

Challenges in the Research

As a historian, I was posed with number of challenges for using an unconventional methodology. These challenges varied from one setting to the other. Each archival site operates according to its own rules and regulations. Conducting research at number of archives both in the First and Third World taught me the way to cope with different systems with patience. The highly systematic and organised archives of the US and UK provided all the material that I looked for within a considerably shorter time period. But the FPA resource centre, which was subjected to floods twice during the last decade, also managed to retrieve the material that I was looking for by exploiting the personal contacts of the director of the resource centre.⁷⁷ This process took some time, as the holders of the archival material had to be reminded several times by telephoning them. I was also given

⁷⁷ The director of the resource centre at the FPA retrieved some old FPA Annual Reports for me from senior retired members of the FPA by contacting them personally, since some library copies were destroyed due to floods in year 2003.

access to the Population and Information Centre (PIC) library, which has been closed since 2009 due to lack of funds purely because the librarian of the PIC and FHB are friends and identified me as a diligent researcher. I find this personal touch at efficiency rather fascinating, despite in the context of the lack of a proper institutional framework in these Third World libraries.

The only difficulty I faced during my interviews with WWC attendees was their constant reference to me as 'doctor'. Since they are used to doctors interviewing them for various researches, they found it hard to remember that I am not a medically trained person. Further, they started asking for treatment for various ailments, so I had to remind them that I am not a medical doctor but a historian. In fact, they were first bemused about a historian's interest in the woman's body, because they saw bodies as a territory confined to the interest of medical personnel. I had to constantly turn down their medical queries and remind them that I am a historian.

Structure of the Thesis

Chapter One explores the evolution of the women's health discourse in state strategy that worked towards cementing Sri Lanka's special status as a development 'success' story. In particular, chapter One investigates how international and local demographers wove Sri Lanka into a broader narrative about poverty, population, women's health and development across the globe. Through a careful reading of works of demographers, I trace Sri Lanka making its

mark on the demographic map of the world as an ‘interesting case study’ in the 1950s, becoming a ‘development model’ for South Asia in the 1970s and the survival of this ‘model’ status during the turbulent decade of the 1990s. Within this trajectory towards becoming a ‘development model’ and a women’s health success story, population and women’s health emerged as interconnected categories in policy making. Even though women’s health played a dominant role in the state building project of independent Sri Lanka until the late 1980s, this was disturbed during the turbulent decade of the 1990s when the state deployed women’s bodies giving priority to the nation building project.

Chapter Two provides the institutional history of family planning. Through an account of the early family planning efforts in the 1930s, pioneers of the FPA, global politics of funding family planning programmes in the 1950s, and the Sri Lankan state taking the responsibility of planning families in the mid-1960s, I set out the institutional history of the family planning programme of Sri Lanka from a fragmentary birth control movement to the re-branding of family planning as ‘reproductive health’ after the United Nation’s International Conference on Population and Development in 1994. In so doing, this chapter shows how the ‘cult of population control’ replaced the maternalist welfare ideology in Sri Lanka by the 1970s and became the official ideology on women’s health by the 1980s.

Chapter Three uses the history of ‘the Pill’ in Sri Lanka to show how the broader global discourse on population control played out in the Sri Lankan national context. It explores the fraught story of Sri Lanka as a site for Pill trials in

the 1960s, and popular reactions to the widespread availability of the Pill by the mid-1970s. In particular, this chapter explores how the universal population control as development discourse of the state came under strain when confronted by the challenges of maternalist policies in an ethnically divided nation. Through a cross reading of Sri Lankan research reports and the correspondence of pioneers of Sri Lankan and international family planners, I show how Sri Lanka entered into the global pill trials as a laboratory site, prompted a discussion on contraception. I also explore the moral values around women's bodies and ethnicity, which resulted in terming the Pill *vanda beheth* (pills of sterility) in the late 1960s. Further, through my analysis of International Planned Parenthood Federation (IPPF) reports on the marketing programme of the contraceptive *Mithuri*, (Female Friend) in 1974, contemporary Sinhalese and English newspaper articles, advertisements and interviews with one of the earliest Ayurvedic physicians trained on family planning methods in 1974, one of Chinnatamby's students and Chinnatamby's successor at the FPA, I show how women's health and bodies became the ground on which market forces (*Mithuri*) replaced ethnic forces (*vanda beheth/pethi*).

Chapter Four retells the history of the turbulent decade of the 1990s, how its economic, military and political policies side-lined issues of women's health. Up until the 1990s, the women's health agenda of Sri Lanka and the international development and population control agenda, although not identical, co-existed in mutual intelligibility and mutual instrumentality. The 1990s was an extremely

turbulent decade for Sri Lanka. The Sri Lankan state re-framed and mobilised women and their bodies through ideologies and discourses of ‘patriarchy’ and ‘motherhood’ in response to the economic, political and governmental turmoil of the decade. Chapter Four in a way acts as a preface to Chapter Five. By pointing out different tropes of ‘motherhood/womanhood’ (docile girls at the FTZs, brave mothers in the Gulf and the mothers of war heroes) and the human rights violations of the 1990s, I argue that Sri Lanka was not in an appropriate mind-set to introduce the paradigm shift in women’s health—reproductive health and rights—advocated at the ICPD in 1994.

In Chapter Five, I argue that the launching of the island wide Well Woman Clinic (WWC) programme in 1996 and the designing of the Population and Reproductive Health Policy in 1998 as consequences of the ICPD are both problematic and ambitious ventures. Because in an environment where human rights are routinely undermined, just like in the 1990s Sri Lanka, it is unlikely if not impossible to even ‘imagine’ reproductive rights. Furthermore, due to the state’s framing of women’s bodies for social reproduction as a response to the turbulent events of the 1990s, neither women nor bureaucrats or doctors were free to ‘imagine’ the new ideology of women’s health ‘beyond reproduction’.

This is an attempt to write a critical history of women’s health in post-independence Sri Lanka by challenging the ‘success story’ put forward by development economists, demographers and public health officers. This is neither a history of the FPA nor a demographic history, but a careful analysis of the

women's health programme as state strategy in twentieth century Sri Lanka. By bringing discourses on woman's body and women's health into a unified analytical framework I was not only able to bring out the subjugated stories of women's corporeal experiences but was also able to broaden the understanding of women's health in Sri Lanka. I conclude this thesis by suggesting that this is the right moment for Sri Lanka (after the end of ethnic conflict) to put forward an all encompassing reproductive health and rights approach towards women's health by releasing the woman's body from its development, national and ethnic obligations.

Chapter One

Population, Development and Women's Health in Post-Independence Sri Lanka (1950–1990)

Abstract

This chapter explores the evolution of the women's health discourse in Sri Lankan state strategy of cementing Sri Lanka's special status as a development 'success' story. In particular, the chapter investigates how demographers in Sri Lanka and elsewhere wove Sri Lanka into a broader narrative about poverty, population and women's health across the globe.

Through the careful reading of works of international and local demographers, I trace the trajectory of Sri Lanka making its mark on the demographic map of the world as an 'interesting case study' in the 1950s and becoming a 'development model' for South Asia in the 1970s. In the process of the country becoming a 'development model', population and women's health emerged as interconnected categories in development policy making. Due to the turbulent decade of the 1990s, this success story was challenged as the state could not confer reproductive rights to women, which was the key aim of the International Conference on Population and Development (ICPD) held in Cairo in 1994.

By reading census reports from 1881 to 1955 and development plans of post-independence Sri Lanka from 1955 to 1998 against the grain, I explore the emergence of population first as a question and then as a problem. Further, through the evaluation reports published by the Ministry of Plan Implementation, the secondary sources of the architects of development plans of the third world, interviews with key population policy implementers of that time, I discuss the official rhetoric and the ideology of population and the blurred boundaries between state population policy and the national family planning policy. This in turn created the 'common-sense' presupposition which still prevails in Sri Lanka that women's health equals reproductive health. By doing so, I argue that the country's 'model' status worked against the possibility of imagining women's health and bodies 'beyond reproduction'.

Introduction

As pointed out in the Introduction, internationally renowned demographers, development economists and health experts hailed Sri Lanka as a 'development model' for South Asia by the 1970s due to low fertility and mortality levels, increasing life expectancy, high women's literacy rate, women's empowerment and sound public health services.⁷⁸ It is clear that one of the drawbacks of these favourable social indicators was that population was brought under surveillance, especially those sections that the First World considered 'problem populations' of the Third World.⁷⁹ In other words, independent Sri Lanka emerged as a 'development model' for South Asia mainly because of its steady control of the population growth rate due to state initiated welfare policies such as free education and public health services. Since population is seen in the development discourse as one of the main determinants of development, women's health emerged as the main development indicator for evaluating the state building project of independent Sri Lanka.

This chapter examines what development discourse produces in relation to women's health in Sri Lanka: that is the erasure of the possibility of imagining women's health and bodies 'beyond reproduction'. As a consequence, women's health remains limited to reproduction and is articulated in terms of numbers, trends and projections that paint a positive picture about women's status and

⁷⁸ Kirk, 'Natality in the Developing countries', 1969, Caldwell, J.C. et al., 'Is marriage delay a multiphase response', 1981 and Myrdal, 1968.

⁷⁹ Agreeing with Akhil Gupta, I do not simply mean a geographical space by the terms 'First World' or the 'West' but the concept that is determined by space, power and knowledge. In the same sense I use to term 'Third World' not as a geographical entity but a historical construct.

health in Sri Lanka. This chapter provides an introduction and overview of the trajectory of Sri Lanka's women's health from its 'success story' in the 1970s to the crisis situation of the 1990s. I argue that by failing to achieve development during the past four decades, this 'model' status has not only become a fallacy today, but also silenced women's bodies by denying them reproductive rights.

The first part of this chapter examines how Sri Lanka became a case study and then a 'model' to South Asian countries in the global population and development debate. The second part of this chapter examines how population was addressed in official Sri Lankan rhetoric in order to achieve the so called 'model' status. I will examine the emergence of population as a 'question' in census reports and as a 'problem' in development plans and how population planning became an integral part of the national planning ideology of the late 1950s. The third part of this chapter questions the official—institutional and policy making—response to the population 'problem' of the state. Even though measures were introduced earlier to curb the population growth rate, it took four decades for the state to formulate a population policy. The fourth part of this chapter provides an overview of the political and economic context of 1990s Sri Lanka in order to show why the reproductive health and rights approach was not possible to achieve in women's health discourse in the 1990s.

Sri Lanka Becoming a 'Case Study' within Population Research

Before Sri Lanka acquired independence in 1948, it was seen as a 'model colony' of the British Empire. According to the nation's most eminent historians, Sri Lanka's claim to self-government was justified on the grounds that

it was not merely a special case but an unusual one as well because of the strength of her civil society, the political maturity and sophistication of her leaders, and above all the fact that she had had adult suffrage for nearly two decades.⁸⁰

By the time of independence, its model colony status acquired a new significance. Initially, Sri Lanka came onto international researchers' radar with the success of its mortality control; Ceylon was considered a 'true laboratory for demographic research'.⁸¹ Researchers sought to understand the relationship between a drastic decline in mortality rates by 1947 and the malaria control programme launched in 1945 by residual spraying of DDT. They sought to situate both alongside the achievements made in the advances made by the country's civil society. Sri Lanka's mortality rate was brought down from 187.3 in 1946 to 66.1 deaths per 100,000 population in 1947.⁸² This was largely attributed to efficient anti-malaria campaigns launched in 1946.⁸³ According to a study by the Marga Institute

⁸⁰ K.M. de Silva, "The Model Colony"; Reflections on the Transfer of Power in Sri Lanka', A. J. Wilson and Dennis Dalton, (eds), *The States of South Asia; Problems of National Integration*, London, C. Hurst & Company, 1982, p. 83.

⁸¹ Irene Taeuber, 'Ceylon as a Demographic Laboratory: Preface to Analysis', *Population Index*, Vol. 15, No. 4 (Oct., 1949), p. 303. The idea that Ceylon has kept a sound record of census statistics was the firm belief of Kingsley Davies (1950). Both Taeuber and Davies were members of the Office of Population Research at Princeton, USA. Frederiksen (1961) praised Ceylon for having a sound public health system to implement a malaria eradication programme that lowered the death rates of the country.

⁸² Myrdal, *Asia Drama, Vol. III*, New York, Pantheon, 1968, p. 1569.

⁸³ Ibid.

commissioned by the United Nations Research Institute for Social Development (UNRISD), due to this decline in mortality and a stable birth rate, the population growth rate rose from '1.4 in 1945 and 1.8 in 1946 to 2.5 in 1947 and 2.7 in 1948. With net migration, the growth of population reached 3.0 percent 3.1 percent, and 3.2 percent in the years 1948–1951.'⁸⁴

Before long, Sri Lanka also became a site of fertility control and international enquiry. This was indeed the opposite of the Western experience where, instead of a result of state policy death, rates went through a steady decline in relation to the economic progress and industrialisation, which was followed by improved living conditions. Demographers such as Abhayaratne (1950), Cullumbin (1950), McDonald (1951), Kingsley Davis (1956), Frederiksen (1961), Newman (1965, 1970), Jones and Selvaratnam (1972) and R.H. Gray (1974) found this new demographic situation in Sri Lanka an interesting case study for a newly independent agricultural state.⁸⁵

Since many of these demographers believed that rapid population growth was the root cause of poverty, population control measures and policies were introduced to the Third World by the West as the first step towards development.⁸⁶ With technical and financial assistance from international development agencies such as the Swedish government, the International Planned

⁸⁴ *Welfare and Growth; A case study of Sri Lanka prepared for the UNRISD project: The Unified Approach to Development Planning and Analysis*, Colombo, Marga Institute, 1974, p. 4.

⁸⁵ Peter Newman, 'Malaria and Mortality', *Journal of the American Statistical Association*, 72:358 (1977), p. 257.

⁸⁶ Hartmann provides a very insightful analysis about the Malthusian theory of overpopulation creating a scarcity of resources in her seminal work of *Reproductive Rights and Wrongs*, 1995.

Parenthood Federation (IPPF), the World Health Organisation (WHO) and the United Nations Fund for Population Activities (UNFPA), Sri Lanka soon adopted the dominant development ideology and thinking on global population discourse.

Concurrently, the Population Association of America (PAA), established in 1930, carried out population research in developing countries which gave legitimacy for population to become a subject of scientific research.⁸⁷ Eminent academics who participated in the First World Population Conference held in Rome from 31 August to 10 September 1954 decided to

generate fuller information on the demographic situation of the developing countries and to promote the creation of regional training centres which would help to address population issues and to prepare specialists in demographic analysis.⁸⁸

Following this, population study centres were established at American universities through Ford Foundation grants in the early 1950s. Quoting Hodgson, Greenhalgh points out that, ‘in one decade, between 1951 and 1961, seven new programs were funded; in another six years, between 1961 and 1967, nine more were added.’⁸⁹ As Hartmann puts it, the Ford Foundation, the Population Council and the Rockefeller Foundation facilitated the development of ‘a powerful cult of population control’ in US academia, which led to the myth of overpopulation in

⁸⁷ The PAA was an offshoot of the American National committee of the International Union for the Scientific Study of Population (IUSSP) formed in 1927 with biologist Raymond Pearl of Johns Hopkins University.

⁸⁸ <http://www.un.org/en/development/devagenda/population.shtml> (Accessed on the 5th Nov. 2012).

⁸⁹ Susan Greenhalgh, ‘The Social Construction of Population Science: An Intellectual, Institutional, and Political History of Twentieth-Century Demography’, *Comparative Studies in Society and History*, 38 :1996, p. 43.

the 1960s; 'a philosophy based on fear, not understanding'.⁹⁰ Research centres were set up, researches were funded and conferences were held to discuss the findings and to make population policy decisions for the Third World, thus creating a discourse on population and development. From the process, demography emerged as a modern science while populations of Third World countries became research sites and research subjects.

By the 1950s, populations on research sites were computed and analysed according to the demographic transition theory and the results were used to design development plans for the studied regions. During the golden decades (1960s, 1970s) of American demography, Stanford University biologist Paul Ehrlich introduced the term 'population bomb' to describe the rapid population growth in Asia.⁹¹ As a result of the population boom in post-war Ceylon, Jones and Selvaratnam say that Sri Lanka became subjected to academic scrutiny in the 1960s, and this trend further popularised the term 'population explosion'.⁹² According to Corea, Lakshman and Tisdell, Sri Lanka stood out in the Asian demographic picture, because population growth rate was brought under control (nearly 3 percent per annum in the late fifties to about 2.2 percent by the late sixties)⁹³ as a result of the improvements in the field of social indicators such as high literacy rates, rise in female age at marriage, women's employment and family planning activities.

⁹⁰ Hartmann, *Reproductive Rights and Wrongs*, p. 4 and 104.

⁹¹ Ibid., p. 4.

⁹² Gavin Jones and S. Selvaratnam, *Population and Economic Development in Ceylon*, Colombo, Marga Institute, 1972, p. 20.

⁹³ Gamini Corea, 'Ceylon in the Sixties', *Marga Quarterly*, Vol. 1, No. 2 (1971), p. 2.

Thus by the late 1960s, Sri Lanka turned out to be a case of interest and a puzzle for scholars of not only demography but economics and development studies. Though its social indicators were well above the standards of other developing countries, economic progress was still alarmingly slow. In comparison to other developing countries, Sri Lanka became identified as an 'outlier'.⁹⁴

Prior to questioning Sri Lanka's 'model' status in South Asia, it is important to give a brief history of the development of demography as a discipline in Sri Lanka.

History of Demography in Sri Lanka

Demography developed as a discipline in Sri Lanka in the early 1970s. The Demographic Training and Research Unit (DTRU) was established in 1973 at the Faculty of Arts of the University of Sri Lanka (now University of Colombo) with the assistance of the UNFPA. The first set of young demographers was trained mainly by the Australian National University.⁹⁵ One of the main objectives of the DTRU was to 'encourage the scientific study of population besides teaching population courses at the university'.⁹⁶ The major aim and long term objective of the Unit was

⁹⁴ Lakshman, and Tisdell, 'Introduction to Sri Lanka's Development', p. 9

⁹⁵ In the academic year of 1972/73, a six million dollar multi-disciplinary population programme was launched by the UNFPA in Sri Lanka and the Demographic Training Unit (DTRU) was one of them, but DTRU did not directly deal with family planning programmes. See *Population and Family Planning Activities in Sri Lanka*, Colombo: Population Division, Ministry of Plan Implementation, 1979, p. 26.

⁹⁶ *Population Problems of Sri Lanka (Proceedings of a Seminar)*, Demographic Training and Research Unit, University of Colombo, Sri Lanka, 1976, p. v.

to promote the understanding among policy makers and planners that there are inter-relations between demographic changes and socio-economic factors. This project was considered by the first Director of the DTRU as 'the academic backbone in the country to develop, modify and evaluate population policies for the Government'.⁹⁷

During the 1970s and 1980s, global demographic research incorporated anthropological research methods in order to understand the discrepancies between demographic predictions based on demographic transition theory and actual demographic findings. Studies were undertaken by Australian demographer John Caldwell together with the Sri Lankan demographer Indra Gajanayake on the change of marriage patterns in Sri Lanka during 1985 and 1987 in order to understand its impact on fertility trends. This demographic study for the first time used a combination of survey and anthropological methods.⁹⁸ With a new zeal in demographic research, demographers tried to find trends, special cases and best models in the Third World and provided demography with a new legitimacy as a social science.

Is Sri Lanka Actually a 'Development Model'?

Studying these trends in the 1970s, demographers identified Sri Lanka as a 'development model' or a template, which other countries in the region should follow. But of course, the model was not free of its own problems.

⁹⁷ Ibid. p. vii.

⁹⁸ John Caldwell, Indra Gajanayake, Bruce Caldwell and Pat Caldwell, 'Is Marriage Delay a Multiphasic Response to Pressures for Fertility Decline?', p. 337.

The first demographic study of Sri Lanka was published in 1956 by N.K. Sarkar, stated that Ceylon had many features in common with other Asian countries and it also possessed 'an unusual wealth of demographic data.'⁹⁹ However, he did not go into detail to explain what the 'unusual demographic data' was, assuming it was general knowledge in academia at that time. He also claimed that this was the reason why Sri Lanka became a case of interest to Western demographers. According to the WHO the rise of life expectancy at birth between 1946 and 1954 (an increase of 15 years from 44 to 59 years) was 'an unparalleled achievement in world demography.'¹⁰⁰ Sarkar may have been referring to this as unusual demographic data in his article published in 1956. In any case, from the 1960s onwards, there was a growing consensus among demographers that Sri Lanka's remarkable demographic performance was the result of the colonial legacy of a sound public education and health system.

Writing in 1969 about the fertility trends in developing countries, Dudley Kirk, professor of demography at Stanford University, found 'Ceylon as an interesting case, a sort of Ireland of Asia, in which late marriage has reduced natality.'¹⁰¹ The Sri Lanka Fertility Survey conducted in 1975 (as part of the World Fertility Survey Programme) supported this statement and 'spread the fame of

⁹⁹ N.K. Sarkar, 'Population Trends and Population Policy in Ceylon' *Population Studies*, 9:3(1956), p. 195. In his book *Demography of Ceylon*, 1957, he gives an account of descriptive assumptions on the size of the population made by colonial administrators such as Tennent (1859) and Forbes (1840) based on the ancient ruins of kingdoms, irrigation systems and chronicles (Mahavamsa), which later census superintendents such as Denham (1911) and Turner (1921) refuted. (pp. 6-12).

¹⁰⁰ *Six Year Programme in Investment 1954/55 to 1959/60*, Planning Secretariat, Govt. of Ceylon, 1954, p. 377.

¹⁰¹ Kirk, 'Natality in the Developing countries', p. 80.

Asia's Ireland (Alam and Cleland 1981; Casterline, Williams and McDonald 1986; Department of Census and Statistics 1978; McCarthy 1982; D.P. Smith 1980; Trussell 1980).¹⁰² Similar views were held by demographers such as Wright and Fernando on the relationship between the rise in female age at marriage and the decline of population growth.¹⁰³

Caldwell *et al.* (1989) identified Sri Lanka as the leader in Third World Asia's change in marriage patterns; by the mid-1970s Sri Lankan females were marrying not at puberty but a decade later. There have been several studies of age at marriage, or its relative contribution to lower fertility in Sri Lanka.¹⁰⁴

Further de Silva notes that,

unlike India, Sri Lanka never had the custom of child marriage, premarital pregnancies are rare, and marital dissolution is insignificant (McDonald, Ruzicka & Caldwell, 1981), thus age at marriage is the determinant of a woman's total reproduction.¹⁰⁵

According to Jones and Selvaratnam writing in the early 1970s, 'Ceylon has been a forerunner for the countries of Southern Asia in many matters related to social and economic development.'¹⁰⁶ First, there was a sharp decline in mortality in the late 1940s, second, Sri Lanka had excellent social welfare services unmatched

¹⁰² Caldwell, Gajanayake, Caldwell and Caldwell, 'Is Marriage Delay a Multiphasic', p. 338. See also W. Indralal de Silva, 'The Ireland of Asia: The Trends in Marriage Timing in Sri Lanka', *Asia-Pacific Population Journal*, United Nations (ESCAP), Bangkok, vol. 12(2):3-24, 1997, p. 3

¹⁰³ Wright, N.H., 'Recent Fertility Change', *Demography*, 5:2(1968), Fernando, D., 'Recent Fertility Decline in Ceylon', *Population Studies*, 26:3(1972) and Caldwell, J. Gaminiratne, K.H.W. et. al., 'The Traditional Fertility Regulation in Sri Lanka', *Studies in Family Planning*, 18:1(1987).

¹⁰⁴ (Fernando, 1976; Wright, 1968, 1970; Smith, 1980; Trussell, 1980; Immerwahr, 1981; Langford, 1981; McCarthy, 1982; Smith, Shahidullah & Alcantara, 1983) stated in W.I. De Silva, 'Age at Marriage in Sri Lanka: Stabilising or Declining?' *Journal of Biosocial Science*, 22:4(1990), p. 395. Also see Caldwell, Gaminiratne, et al. 'The Role of Traditional Fertility Regulation', pp 1-21.

¹⁰⁵ de Silva, 'Age at Marriage in Sri Lanka', p. 403.

¹⁰⁶ Jones and Selvaratnam, *Population and Economic Development*, p. ii.

anywhere in the region, and, third, a severe foreign exchange problem emerged by the 1970s. All these experiences made Sri Lanka to be studied as a model in the region.¹⁰⁷

Taking life expectancy into consideration, Rao said in the 1970s, 'Sri Lanka occupies a place of pride along with Japan, Mauritius and Mexico in achieving phenomenal increases in life expectancy since the post-war period.'¹⁰⁸ Lakshman and Tisdell noted that according to UNDP measures of 'countries of low human development' in 1998, the achievements of Sri Lanka in 1948 were relatively high by the standards of developing countries.¹⁰⁹ Sri Lanka was much ahead in social indicators among South Asian countries.

However, despite its model status, Sri Lanka failed to live up to the promise of this legacy even by 2012. How do we understand the duality of reaching replacement-level fertility in 1994, six years prior to the UN's estimate, and at the same time failing to achieve 'development' according to the 2012 UNDP report.¹¹⁰ To answer this question, we need to dig further into the discourse and practices of population and development in Sri Lanka. Where did Sri Lanka go wrong in its development trajectory, despite adhering to the approved path?¹¹¹ Or rather, was

¹⁰⁷ Ibid.

¹⁰⁸ S.L.N. Rao, 'Mortality and Morbidity in Sri Lanka', *Population Problems of Sri Lanka (Proceedings of the a Seminar)*, Demographic Training and Research Unit, University of Colombo, Sri Lanka, 1976, p. 27.

¹⁰⁹ Ibid. p 27.

¹¹⁰ C.M. Langford, 'Fertility Decline in Sri Lanka: Could Fertility Now Be at about Replacement Level?' in Zeba Satha and James Phillips (eds), *Fertility Transition in South Asia*, Oxford University Press, 2001, p. 131.

¹¹¹ According to the established assumption, the first step towards development is to reduce the population growth rate to replacement-level fertility.

Sri Lanka trying to answer the wrong set of questions all along? What do the above mentioned examples imply?

At first, the qualities that make up Sri Lanka's exceptional status seem to imply a steady and gradual progress towards 'development', by keeping its population growth rate well under control. According to international and national demographers, Sri Lanka's demographic chart is very similar to that of modern Western developed countries. Then why was the promised development not achieved by Sri Lanka after adhering to the path set out by international development organisations? I believe Sri Lanka was trapped in the fallacy of believing in its 'model' status, which has painted a deceptive picture from the beginning. By saying so, I do not wish to disregard the claims made by renowned demographers based mainly on statistics. It is not the statistics or the method of acquisition or evaluation of those results that I question, but the conclusions made on the basis of these numbers. Due to the inherent link between population, women's health and women's bodies, it is difficult to treat population as the most crucial determinant of development. Since, population is not only about numbers, growth rates and providing the work force to develop the country, but about women giving birth, women's bodies and their perception of being mothers and having families. Thus the numbers, growth rates and work force mask a sensitive aspect of human lives, which has not been acknowledged by demographers, economists and development experts so far.

For over fifty years, the relationship between population and development were treated as closely related concepts by the West, and this connection had become an unquestionable truth: development could only be achieved if population growth rate was controlled. Sri Lanka's demographical advancement was claimed as universal truth by international demographers and was treated as gospel by local policy makers. Consequently, this led to the commonsensical presupposition, still prevalent in Sri Lanka, that women's health equals reproductive health, which needs to be carefully 'controlled and planned'. This in turn makes woman's body an implicit category of analysis. In his intellectual inquiry into the prevalent development ideology in Third World countries, Escobar says that population programmes made population an 'object' which needs vigilant scrutiny and careful planning for development purposes.¹¹² Thus, population programmes were carried out along technically correct, modern and scientific lines. Renowned demographers such as Frank Notestein, Kingsley Davies, Dudley Kirk and Caldwell did not see the other side of numbers, and their implications to women's bodies, when these claims about Sri Lanka were put forward.

Seen through a scientific and rational lens, Sri Lanka's status as a 'model' in South Asia appears to be a fallacy, even though statistics and numbers provided its very basis. First, this 'model' status failed to deliver the promised 'development'

¹¹² Escobar, A., 'The Making and Unmaking of the Third world Through Development', Rahnema, M. with Bawtree, V. (eds), *The Post Development Reader*, London and New Jersey, Zed Books, 1997, p. 87.

even after six decades. Secondly, Sri Lanka claimed to be a development model despite not having a well-articulated population policy until the late 1990s. Should not population policy be the guiding mechanism for a country to reach its 'model' status? Though the 'question' of population was taken up in the census report of 1921, Sri Lanka took another four decades (1960s) to address population as a 'problem' by incorporating family planning in the government's maternal and child health programme and seven decades (1990s) to formulate a population policy. The Population and Reproductive Health policy was formulated only in 1998. I maintain that the control of the population growth rate without a population policy is in itself a demographic marvel. How was this done? Such a remarkable achievement calls for a thorough analysis of the intricate relationship between development and women's health.

According to the former medical director of the Family Planning Association (FPA) and retired secretary to the Ministry of Plan Implementation during the 1970s and 1980s, unlike in the sterilisation camps of India in the mid-1970, population initiatives in Sri Lanka were implemented in a non-coercive manner. Population policy initiatives, such as the social marketing of contraceptives and sterilisation incentives, were implemented as and when it was deemed appropriate by policy makers. In explanation, she also said that Sri Lanka was able to make use of a less intrusive approach, because the FPA and the government had educated the public on family planning methods through public

health workers.¹¹³ However, the former medical director of the FPA did introduce sterilisation incentives in the early 1980s. This means that there were implicit coercive policy measures in place to control the population growth rate without really looking into the deeper implications of population growth, structure and composition. Eventually this paved the way for Sri Lanka to become a 'model' for South Asia. Then is not this model status rather ambiguous?

I see Sri Lanka not as a development 'model', but as an island caught between this fallacy created by the West and trying desperately to understand its own meaning of development, while grappling with its priorities, demands and expectations. Though there appears to be a considerable time lag between the introduction of population control measures and the formulation of a comprehensive population policy, prior to interrogating this delay, I deem it necessary to inquire into how population was addressed in the official rhetoric of independent Sri Lanka. By tracing the genealogy of population policy in the post-colonial state, I argue that the delay in formulating a population policy was the result of the controlling and planning ideology that prevailed within the official rhetoric on population. In other words, the delay was the result of the official silence on women's rights over their bodies and of the need to govern women's bodies to achieve the development targets set by international organisations.

¹¹³ Interview with the former Medical Director of the FPA on 16 February 2010 at her residence in Colombo.

Emergence of the Official Rhetoric on Population in Sri Lanka

The sources that I use to determine the official rhetoric on population are the census reports of 1881, 1891, 1911 1921, 1931 and 1946 and the development plans of post-independence Sri Lanka. Foucault's analysis of population in his genealogical tracing of the history of sexuality in Western civilisation shows that there is an intimate bond between the state, its population and the effort by the state to govern, regulate and monitor all variables of population.

One of the great innovations in the techniques of power in the 18th century was the emergence of 'population' as an economic and political problem: population as wealth, population as manpower or labour capacity, population balanced between its own growth and the resources it commanded. Governments perceived that they were not dealing simply with subjects, or even with a 'people,' but with a 'population,' with its specific phenomena and its peculiar variables: birth and death rates, life expectancy, fertility, state of health, frequency of illnesses, patterns of diet and habitation.¹¹⁴

Both census reports and development plans have specific ways of moulding a scattered, disorganised and unsystematic people into populations and citizens. Modern censuses in the nineteenth century, especially during British colonial domination, tried to understand subjugated people as a population residing within a defined territory of land. Thus, censuses organised subjugated people on behalf of the state as a population. Scott sees censuses as the state's creation of 'a complete inventory of its population.'¹¹⁵ This was achieved through counting people and

¹¹⁴ Michel Foucault, *The Will to Knowledge: The History of Sexuality Vol. 1*, translated by Robert Hurley, London, Penguin Books, reprint under the present title in 1998, p. 25.

¹¹⁵ James Scott, *Seeing Like a State; How Certain Schemes to Improve the Human Condition Have Failed*, (Yale University Press, 1998), p. 71.

recording their names, ethnicity, caste, marital status, religion and wealth. Thus, the mode of understanding people in the colonies was according to Western measurement. These measurements and statistics made the colony legible to the ruling colonial powers.¹¹⁶ I see development plans designed in post independence Sri Lanka as instruments continuing to create the same legibility through monitoring, regulating and governing the populations of these so called newly independent states. The recording of mortality rates, fertility rates and migration rates serves the same purpose.

Thus I see population, development and planning as a cluster of closely knit concepts, which gets its full meaning by feeding into each other. If one concept is left out from this cluster the others lose their comprehensive meaning. In this section I will examine each concept one by one in order to decipher the official rhetoric of population in independent Sri Lanka.

For the purpose of the remainder of this chapter, I will look at the official rhetoric of population in Sri Lanka in two distinctive phases: colonial Ceylon (from 1881 to 1955) and independent Sri Lanka (from 1955 to 1998). These periods were not decided according to the accepted divide marked by independence. Since, the first development plan of 1955 speaks volumes about the formulation of the official rhetoric on population, instead of the political events I decided to take the year of its inception as the watershed. The year 1998 marks the formulation of

¹¹⁶ Ibid., pp. 25–33, for a very illustrative analysis of the politics of measurement in relation to state building and state craft. See also Scott on census reports as state projects of legibility and standardisation on p. 64–71.

the first population policy in Sri Lanka. The colonial phase will be looked at through the census reports of Ceylon and the independent phase through development plans, because the two sources address two different phases of population rhetoric: namely 'population as a question' in census reports and 'population as a problem' in development plans. The main characteristics of population policy and the meaning of population policy under each government that ruled since independence do not form part of this thesis, since population policy making was neither a linear process nor an innocent process but a political one. In the next section I will unravel other trajectories of population policy making in post-independence Sri Lanka.

Population as a 'Question' in Ceylon (1881–1955)

As I have mentioned above, though population was taken stock of at various occasions in ancient Sri Lanka under the kings and during the Dutch period, the first modern census took place as instructed by the secretary of state on 26 March 1871, simultaneously with Great Britain and Ireland.¹¹⁷ According to the 1871 census report, there were 2,405,287 inhabitants of Ceylon.¹¹⁸ Thereafter population was taken stock of decennially until 1981.¹¹⁹ Later, due to the ethnic conflict engulfing the north and the north east (1983–2009), the affected areas were not included in some years. The last population census of the whole island

¹¹⁷ *Census of Island of Ceylon 1871, General Report*, compiled by G.S. Williams, Colombo, Government Printer, Ceylon, 1873, p. ix.

¹¹⁸ *Ibid.* p. xv.

¹¹⁹ W. Indralal de Silva, 'Population Planning Strategies and Programmes in Sri Lanka', *Asian Profile*, 23:5, (1995), p. 404.

was taken in 2010. The population of Ceylon numbered 2,759,738 persons in 1881, 3,007,789 persons in 1891,¹²⁰ 3,565,954 in 1901 and 4,110,367 in 1911.¹²¹

The 1911 census report compares the percentage of increase in population and also population density since the first census of 1871.¹²² For the first time the term 'over-population' was used in the 1921 census report in relation to the density of the population. The '[c]rude density of Ceylon in 1921 was 178 persons per square mile.'¹²³ Further, explaining Malthusian theory, the census report of 1921 says that Ceylon has to deal with the question

why population is restricted... Population is necessarily limited by the means of subsistence. But it is to a people's advantage to check its increase by other means than by death from starvation, and the more progressive races are now rather to be imagined as aiming at a higher standard of comfort, or an increased real income per head, than as continually pressing "hard against the limits of the average food".¹²⁴

Even though the report did not suggest that Ceylon was overpopulated in 1921, colonial officials were paying attention to the notion of overpopulation by measuring population growth rate and means of subsistence. Emphasising comfortable living conditions of more progressive races, the 1921 census report warns that if population increase was not checked by other means people will die

¹²⁰ *Census of Ceylon 1891: A General Report, Volume I*, Compiled by Lionel Lee, (Ceylon civil Service, Superintendent of Census), Ceylon, Government Printer, 1892, p. 11.

¹²¹ *Ceylon Census of 1911, The Review of the Results of the Census of 1911* by E.B. Denham, Colombo, Government Printer Ceylon, 1912, p. 12.

¹²² *Ibid.*, p. 12.

¹²³ *Census Publications, Ceylon 1921, Report on the Census of Ceylon, 1921, Vol. 1, Part I*, L.J.B. Turner, (superintendent of Census and Director of Statistics, Ceylon), Ceylon, Government Printer, 1923, p. 18.

¹²⁴ *Ibid.*, p. 24.

of starvation. Thus the report was truly based on the principles of population advocated by Malthus.

The 1946 census report clearly states that 'Ceylon by comparison cannot be set down as an overpopulated country.'¹²⁵ More importantly, it notes that the increase in population was alarming and any small disturbance in the villagers' normal equilibrium will bring them to near starvation.¹²⁶ Quoting Kingsley Davies, the 1946 census report suggests formulating a national population policy in accordance with 'international demographic planning based on an equalisation of resources and standards of living of different peoples.'¹²⁷ Emphasising the quality of the population, it proposes to develop a eugenic consciousness among people through the spread of information on informed sexual selection.¹²⁸ Although, Ceylon was not considered an overpopulated country by 1946, it was keen to improve the quality of the population through the dissemination of information. The 1946 census proposed the planning of population growth by considering various aspects of population and advocated a demographic policy 'on the basis of detailed investigations of the various aspects of the population problem'.¹²⁹ By 1946, it was clear that population was not only about numbers in the census

¹²⁵ *Census of Ceylon 1946, Vol. 1, Part 1, General Report*, A.G. Ranasinha, (Colombo, Ceylon Government Press, 1950), p. 67.

¹²⁶ *Ibid.*, p. 67.

¹²⁷ *Ibid.*, p. 60.

¹²⁸ *Ibid.*, p. 70.

¹²⁹ *Ibid.*, p. 70.

reports, but also about monitoring and planning without letting the population 'grow haphazardly'.¹³⁰

Before the discussion of the main component of this section—the emergence of population as a 'problem' within the development plans of post-independence Sri Lanka—I will briefly outline the emergence of planning as an ideology in the Third World. Unlike in India, economic or development planning was indeed a new exercise in independent Sri Lanka, which impacted democratic state building, nationalism, modernisation and industrialisation. Thus, here I illustrate how planning ideology was weaved into the development plans of post-independence Sri Lanka, which identified population as a 'problem'.

Planning as an Ideology

An early reference to 'planning' in Sri Lanka appeared in the Governor General's address at the opening session of Sri Lanka's first Parliament in 1947.¹³¹ 'My government realises that the future well-being of this country depends to a great extent on the sound development of its resources and that the first step in this direction is Planning'.¹³² However, when analysing the Indian development planning process, Zachariah points out that planning has been an influential

¹³⁰ Ibid., p. 70.

¹³¹ *Welfare and Growth*, p. 43.

¹³² Ibid., p. 43.

driving force for newly independent countries already by the 1930s, due to its successes in the Soviet Union, Japan, the USA, Fascist Italy and Nazi Germany.¹³³

After the Second World War, planning process was forcefully strengthened as America appeared as the model that less fortunate societies should follow; 'America's path to political stability and prosperity through the rational management of its resources, through the application of science and technology to mass production' seemed the path to emulate to become a modern developed nation.¹³⁴ As I have mentioned above, with population studies gaining scientific status in the early 1950s, rapid population growth in the Third World came to be seen as the greatest obstacle for development. As Berly Suitters says, since the International Planned Parenthood Federation's aim was 'to make family planning a part of national development' in Third World countries, it worked out ways and means of providing them with funds for family planning programmes.¹³⁵ Therefore, population control programmes were designed to control the rapid growth of 'problem populations' in the Third World. It became the moral obligation of the First World to facilitate development planning with an emphasis on population programmes of the Third World for the greater good for a greater number. The International Bank for Reconstruction and Development (IBRD) did not hesitate to send 'experts' to help with the development planning process of the

¹³³ Benjamin Zachariah, *Developing India: Intellectual and Social History c. 1930-1959*, Oxford/New York/New Delhi, Oxford University Press, 2005, p. 7.

¹³⁴ Michael Adas, 'Modernization Theory and the American Revival of The Scientific and Technological Standards of Social Achievement and Human Worth,' in David Engerman, Nils Gilman et al. (eds), *Staging Growth: Modernization, Development and the Global Cold War*, Amherst and Boston: University of Massachusetts Press, 2003, p. 26.

¹³⁵ *Fifteen Years of Family Planning in Ceylon 1953-1968*, Colombo: FPA, p.33.

newly independent states of the Third World.¹³⁶ As correctly pointed out by Rahnema, the planning process of the Third World countries ended up making them 'as we (the first world) want them to be.'¹³⁷ Through this process the Third World entered into a new imperial relationship with the First World.

Apart from the pro-West, modern and capitalist mode of development planning, there was another set of ideologies that influenced the planning process of the newly independent states of Asia: the socialist model of self-sufficient planning where the state owns and regulates the resources in an egalitarian manner. Myrdal pointed out that the idea of state ownership and mobilising the production forces of the country for a single cause created not only planning as an ideology but also an emotional momentum of 'new nationalism' for third world countries.¹³⁸ Chatterjee describes this very succinctly in the Indian planning process. "The very institution of a process of planning became a means for the determination of priorities on behalf of the "nation".¹³⁹ Further elaborating this point, he says that the development planning process helped to create a national consciousness across the nation.

In 1938, the Indian National Congress decided to set up the National Planning Committee (NPC). Consequently development planning became part of

¹³⁶ Myrdal, *Asian Drama*, Vol. II, p. 728.

¹³⁷ Majid Rahnema, 'Towards Post-Development: Searching for Signposts, a New Language and New Paradigms' in Majid Rahnema and Victoria Bowtree (eds), *The Post-Development Reader*, London/New Jersey, Zed Books, 1997, p. 392.

¹³⁸ Myrdal, *Asian Drama*, Vol. II, p. 722.

¹³⁹ Partha Chatterjee, *The Nation and its Fragments*, Princeton University Press, 1993, p. 202.

the nation building process of India.¹⁴⁰ However, Sri Lanka's National Planning Council was established only in 1957—nine years after independence. The first document resembling a national plan, the *Six Year Programme of Investment* was designed on request of the IBRD. It was based on the recommendations of the IBRD Mission in 1952.¹⁴¹ Unlike the situation in India, there was no dynamic discussion among academics, civil servants, industrialists and politicians on national planning; the urge for economic planning in Sri Lanka came from international agencies and not as a local initiative. Montague de Silva notes that during 1954 there were approximately forty-six international personnel engaged in various activities of the Department of Health in Sri Lanka.¹⁴² Along with the expertise, development aid came to Ceylon in the form of technical and financial assistance in order to plan and implement development programmes and research in Ceylon.

By the late 1960s, the UK, USA and Canada established institutions to further monitor these regions and make sure that their money and energy were productively used. Several development studies institutes were created in the UK, such as the Institute of Local Government Studies at Birmingham University, the

¹⁴⁰ Ibid., p. 200.

¹⁴¹ *Welfare and Growth*, p. 44.

¹⁴² David Montague de Silva, *Health Progress in Ceylon: A Survey*, Colombo, Ministry of Health, Ceylon, 1956, pp. 6–10. Amongst them were Dr J.H.L. Cumpston (former Director General of Health Services of the Commonwealth of Australia) mandated to report on the working of the medical and public health system of Ceylon, and to advise the government on improving and reforming the system; Dr Abraham Stone from the WHO to report on population control and family planning; Mr Donald Barlow, the eminent British Thoracic Surgeon who visited Ceylon to advise on Thoracic Services; Sir Sydney Caine who paid a visit as the chief of mission of IBRD; Mr R.N. Clarke of the WHO who visited Ceylon to advise on Public Health Engineering; and Prof Abel Wolman of the WHO who came down to advise on managing water resources.

Department of Overseas Administrative Studies at Manchester University and the Institute of Development Studies at Sussex University. These specialised institutions provided special courses in 'medicine, engineering, agriculture, fisheries, co-operatives, management, broadcasting and television, taxation, law, adult education, public administration, customs and excise and immigration.'¹⁴³ Apart from development studies in general, centres for South Asian studies in particular were set up at universities in London, Cambridge and Hull. In Canada, the Centre for Developing Area Studies at McGill University and the Institute for International Cooperation at the University of Ottawa looked into the problems of and undertook research on development programmes carried out in the Third World.¹⁴⁴ What were these institutions for? And why were these institutions established in the First World instead of the third world where the 'problem' resided?

These institutions created an intellectual surveillance in the Foucauldian sense where elites (such as policy makers and academics) of Third World countries were brought into neo-colonial servitude. While it is not exactly true that they were not aware of their position of intellectual servitude, they did not make a conscious attempt to break free; this was especially true of the Sri Lankan elite. Indeed it was an enormous ideological-political struggle and task to break free from neo-colonial servitude and engage in a project of conscious planning of

¹⁴³ *International Assistance for Education for Development; The Colombo Plan Special Topic Report*, considered by the 20th Consultative Committee Meeting held in Manila, Feb. 1971, p. 74-75.

¹⁴⁴ *Ibid.*, p. 75.

developing Sri Lanka in an essentially Sri Lankan way. Unlike in India, no radical political or national movement ever conceptualised in Sri Lanka. No such movement emerged against the British even during colonial rule because the Sri Lankan elite had its own ways of assimilating itself to the power and rule of the British government.¹⁴⁵ This explains why Mignolo's urge for an 'epistemic disobedience'—thinking and imagining beyond what is given and produced, and to disregard all conventions—seemed impossible in the Sri Lankan context.¹⁴⁶ The moment peoples' thinking pattern and imagination are captured and destroyed in the name of scientific rational education, epistemic disobedience becomes a fallacy. The Sri Lankan elite in post-independence Sri Lanka were graduates of Oxbridge; their ideological servitude did not leave space for an epistemic disobedience.

By the early 1960s, planning committees have been created in each ministry, working according to a definitive plan or a programme.¹⁴⁷ This initiative shows that by the 1960s planning has become an ideology, integrated well into the state building project of Sri Lanka. The planning ideology of the 1960s acted as the vehicle for the newly independent states to acquire the consciousness of modern developing nation states. Development planning dealt with development

¹⁴⁵ See A.J. Wilson (2000), K.M. de Silva (1977), Pradeep Jeganathan (1995) and Jayadeva Uyangoda (2003) for a comprehensive analysis of the national movement and sentiments in pre-independence Ceylon.

¹⁴⁶ Walter D. Mignolo, 'Epistemic Disobedience, Independent thought and Decolonial Freedom', *Theory, Culture & Society*, 26(7-8) 2009, p. 160-161.

¹⁴⁷ *The Short Term Implementation Programme and Drafts*, Ministry of National Planning, 1962, p. 42.

problems, thus population was identified as a ‘problem’ in the post-independence development plans of Sri Lanka.

Population as a ‘Problem’ in Sri Lanka (1955—1998)

The 1950s – Planning Mode

After independence, Sri Lanka entered into a new development planning framework through the Colombo Plan devised after a Commonwealth Consultative Committee Meeting held in September 1950 in London.¹⁴⁸ Gunnar Myrdal who worked closely with the design of development plans of South Asia in the late 1950s says, that from the beginning planning has been a technical process in Ceylon as well as in other South Asian countries. Initial planning documents of Sri Lanka such as the *Six Year Plan of 1948* and the *Colombo Plan* of 1950 were not development plans that national plans were expected to conform to. According to Colombage and Karunaratne, the *Six Year Plan of 1948* was more or less an ‘extension of the Budget Speech’¹⁴⁹ presented by the first finance minister of Sri Lanka. The *Colombo Plan* worked as a framework for bi-lateral arrangements, the partnership concept of self-help and mutual help in the development process with the focal areas being human resource development and

¹⁴⁸ *The Colombo Plan for Co-operative Economic Development in South and South-East Asia*. 1950, Presented to Parliament by the Hon. J.R. Jayawardena, Minister of Finance, Ceylon, Government Press, p. 8.

¹⁴⁹ S. Colombage & S.A. Karunaratne, ‘Development Planning and Investment,’ in W. Rasaputra, W.M. Tilakaratne et al. (eds), *Facets of Development in Independent Sri Lanka, Ronnie de Mel Felicitation Volume*, Colombo, Lake House Printers, 1986, p. 197. See also *Welfare and Growth* for a description of the Six Year Programme of Investment as an ad hoc exercise. p. 43.

south-south cooperation.¹⁵⁰ Even though the *Colombo Plan* identified that South and South-East Asia are the most densely populated areas of the world, no effort was taken to control the population growth in Sri Lanka, although, family planning efforts in India were supported by the Colombo Plan. According to Sarkar and Colombage, the *Colombo Plan*, the *International Bank Plan* and the *Six Year Programme of Investment* (1954/55 to 1959/60) emphasised the importance of agrarian economy and did not pay attention to population growth rates.¹⁵¹ Sarkar sees this as a wrong turn taken by the *Colombo Plan* in trying to expand agrarian economy; it proposed industrialisation rather than diversification of the economy.¹⁵² However, more than anything else, I believe, the *Colombo Plan* helped to establish the ideology of planning the economy to achieve development in Sri Lanka.

The minister of finance in 1955, Mr M.D.H. Jayawardane, explained the *Six Year Programme of Investment* (1954/55 to 1959/60) as ‘an attempt to marshal the resources of men and materials in such a way as to derive the maximum benefit for our country. On these foundations we build our hopes for the future.’¹⁵³ Notions of state building and nation building are both embedded in his reference to the ‘marshalling of resources to build our country’s future.’ The *Six Year Programme of Investment* saw rapid population growth as a ‘problem’ and the solution

¹⁵⁰ <http://www.colombo-plan.org/index.php/about-cps/history/> (Accessed on 9 March 2010).

¹⁵¹ N.K. Sakar, *Demography of Ceylon*, Ceylon Govt. Press, 1957, p. 256 and Colombage and Karunaratne, ‘Development Planning’, p. 197.

¹⁵² N.K. Sakar, ‘Population Trends and Population Policy in Ceylon’, *Population Studies*, 9:3(1959), p. 209.

¹⁵³ *Six Year Programme of Investment 1954/55 to 1959/60*, Planning Secretariat, *The Government of Ceylon*, 1955, p. v

suggested was not population control but ‘expansion in the productive capacity of the economy.’¹⁵⁴ However, the importance of family planning and educating parents on family planning (spacing and limiting the number) in order to bring up healthier babies was mentioned in the last paragraph of the Maternal and Child Health section of the plan.¹⁵⁵ In that sense, rapid population growth was identified as a ‘problem’ for the development of the country and recognised in the *Six Year Programme of Investment*.

Within the planning rhetoric of Sri Lanka, rising population growth rate was articulated as a hindrance for development in the *Ten Year Plan of Ceylon* (1959–68). Mr Bandaranaike, who was elected prime minister in 1956, set up the National Planning Council in 1957 and invited a number of distinguished foreign economists to help design a comprehensive national development plan for Sri Lanka.¹⁵⁶ In fact, one whole section in the first chapter of the *Ten Year Plan* (Population Change – The Ceylon Experience, 7–14) is devoted to explain Ceylon’s population change and growth and also to compare it with that of the West in the nineteenth century. Why is it that a comparison with Western countries was so important to plan the development of Sri Lanka? As I have pointed out above, the ideological servitude of the planning officials of Sri Lanka did not allow them to think beyond or escape from the framework given by the West.

¹⁵⁴ Ibid., p. 3.

¹⁵⁵ Ibid., p. 404.

¹⁵⁶ *Papers by Visiting Economists*, Colombo, Planning Secretariat, 1959. (preface).

Despite its limitations, the *Ten Year Plan* assesses the population issue in an analytical manner. Comparing the Indian situation with Sri Lanka, it questions Ceylon's laid back attitude towards its own grave 'population problem' despite the fact that the rate of population growth in India was half of Ceylon's in 1957 (percentage growth of population from 1953 to 57 was 1.3 in India and 2.5 in Ceylon).¹⁵⁷ Acknowledging the population policies carried out in India, Japan and China as part of their planning goals, the *Ten Year Plan* engages with theoretical questions of how to come up with a population policy free from all forms of compulsion; and how to organise campaigns to disseminate information on methods of birth control and make birth control devices readily and cheaply available.¹⁵⁸ The plan also suggests setting up a competent committee of enquiry to study the population problem at length and come up with specific population control measures.¹⁵⁹ Though the disparity between the population growth rate and economic growth rate was mentioned as the most crucial gap to be closed in order to attain development, surprisingly there was no indication of designing a population policy only of the introduction of 'population control measures'.¹⁶⁰ The solution lay in investing in industry and maintaining welfare-state policies.

Though the FPA of Ceylon was established in 1953 as a non-governmental organisation, family planning was not yet incorporated into the government health programme in the 1950s. As I have mentioned in the Introduction, the

¹⁵⁷ *National Planning Council: The Ten Year Plan*, Government Press, Ceylon, Colombo, 1959, p. 12.

¹⁵⁸ *The Ten Year Plan*, Colombo, The Govt. Press Ceylon, 1959, p. 16-17.

¹⁵⁹ *Ibid.*, p. 17.

¹⁶⁰ *Ibid.*, p. 17.

relationship between the FPA and the government at this time could be best described as clandestine. The government supported the cause of family planning in numerous ways but 'persistently refused to make any statement of policy, positive or negative, on the subject' due to its sensitivity.¹⁶¹ The pioneers of the FPA and contemporary politicians knew each other on a personal level but that did not translate into a public relationship.

After identifying population as a 'problem' in development plans what was the official response? First, population policy measures such as social marketing of contraceptives and sterilisation incentives were introduced in the 1970s, but there was no policy document prepared on population until 1998. Secondly, population was brought under the purview of the Ministry of Plan Implementation in 1978.¹⁶² Thirdly, the Population Information Centre (PIC) was opened within the Ministry of Plan Implementation in July 1979 to serve as a clearing house where population information was collected, documented and disseminated.¹⁶³

Official Response to the Population 'Problem'

When having a closer look at the development planning process of post independence Sri Lanka it becomes evident that institutional developments are part of population policy formulation. Thus I discuss the three official responses of

¹⁶¹ Abhayaratne and Jayawardene, *Family Planning*, p. 15.

¹⁶² De Silva, 'Population Planning Strategies', p. 400.

¹⁶³ *The Report of National Workshop on Population Information Exchange & Resource Development in Sri Lanka*, organised by the PIC, Ministry of Plan Implementation and ESCAP with financial support from the UNFPA, held at Colombo, December 10–12, 1980, (foreword).

the state (mentioned above) in relation to the prevailing development planning ideology at the time.

I do not believe that the delay in formulating an official population policy meant that the issue of population was regarded trivial. It was in fact with grave seriousness that the officials concentrated on implementing policy measures (some coercive) to reduce the population growth rate rather than on formulating a population policy document. Thus I see the delay in population policy formulation as a result of the state's keen interest in becoming a development 'model' to South Asia by controlling and planning women's health and silencing woman's body (both her corporeal experiences and reproductive rights). The pressure that bureaucrats underwent to uphold this model status was well captured by a cartoonist in an English daily in 1978 (reproduced below) titled 'World is watching our performance.' The cartoon depicts a bureaucrat as a turtle who is leading Sri Lanka towards development. In that sense, institutional developments were actually part of formulating the population policy.

Formulation of a Population Policy

The need of a population policy for Sri Lanka was first mentioned by Sarkar in an article published in *Population Studies* in 1956.¹⁶⁴ The author used 'population policy' and 'birth control policy' interchangeably in this article. His suggested population policy was aimed at only one goal; reduce the fertility rate of Sri Lanka,

¹⁶⁴ Sakar, 'Population Trends and Population Policy', *Population Studies*, p. 207.

which was increasing at a rapid pace (2.8 percent) in the 1950s. In effect, he confined his population policy to stop children being born. As a firm believer of demographic transition theory, Sarkar said that a birth control policy should follow the socio-economic and cultural modernisation of society, otherwise it is only capable of achieving limited success.¹⁶⁵ He emphasised the political difficulty of implementing a birth control policy, at a time when economic priority lay in industrial development. He believed that industrialisation was the need of the hour for Sri Lanka in the 1950s, so he advocated the achievement of the targets of a population policy as a by-product of industrialisation. Thus his suggestion was to 'draw up the plan of industrialisation in such a way that those forces which lead to a decline in fertility are obtained as a by-product.'¹⁶⁶ Having said that, he did not indicate how such a plan should be drawn up. Given the traditional, socio-cultural context, Sarkar saw the introduction of a population policy as an outright blow to the power of any political party of post-independence Sri Lanka; it was just not the right time in the 1950s.

Taking numerous reports, compiled by international experts on various aspects of the Public Health System of Ceylon, into consideration, the assistant secretary of the Ministry of Health in 1956, Dr David Montague de Silva suggested designing a population policy that could address the 'need for planning of additional employment, social services, housing, food and recreational facilities.'¹⁶⁷

¹⁶⁵ Sakar, *Demography*, p. 246.

¹⁶⁶ Sakar, 'Population Trends', p. 207

¹⁶⁷ De Silva, *Health Progress in Ceylon*, p. 14.

His idea of a population policy was to strike a balance between resources and population growth rate.

Writing about family planning in Ceylon in the late 1960s, Abhayaratne and Jayawardene considered the restrictions placed by the Ceylon government on indentured labour migration from South India to Sri Lanka in the late 1950s as a form of population policy.¹⁶⁸

The above mentioned different viewpoints and interpretations provide us with a window into the mentality of policy makers and academics of 1950s Ceylon. Population was treated merely as a quantifiable object which could and should be controlled, manipulated and planned. Since the economic development priority of the 1950s lay in industrialisation, the designing of a population policy seemed a waste of energy and resources. Though population was growing at the rate of 2.8 percent in the late 1950s, the impact of it was not consciously felt by the government until the mid-1960s, when the government was faced with an increasing unemployment and under-employment problem.¹⁶⁹ Due to the Swabhasha policy (Official Language Act or Sinhalese Only Act of 1956), a large section of the population—popularly known as the children of 56—was entering the work force with secondary or tertiary education without English language proficiency, which was crucial for competing on the labour market especially for

¹⁶⁸ Abhayaratne and Jayawardene, *Family Planning*, p. 15.

¹⁶⁹ *Welfare and Growth*, p. 25.

white collar jobs.¹⁷⁰ In 1965, through a cabinet decision, the Sri Lankan government accepted family planning as a national policy and brought it under the purview of the Department of Maternal and Child Health. This was the first measure taken by the state towards a population policy in Sri Lanka. In 1968, the Family Health Bureau (FHB) was set up at the Ministry of Health, which became the catalyst in implementing the government family planning programme.

The 1960s – Experimental Mode

Despite being involved in formulating the *Ten Year Plan* in 1959, Gunnar Myrdal said in retrospect that the *Ten Year Plan* had ‘high qualities as an intellectual exercise, but nobody took it seriously, least of all the government.’¹⁷¹ However, some attribute the loss of leadership incurred after the sudden demise of Prime Minister Bandaranaike in 1959 and the subsequent mismatch between the interests of the masses and the politicians to the government’s lack of enthusiasm towards implementing the *Ten Year Plan*.¹⁷² However, post-independence development plans had a unique national, emotional connotation for both the policy makers and the people. Unfortunately, it was Sinhalese Buddhist nationalism that was implied in the plans as opposed to a wider Sri Lankan nationalism. Each government claimed their achievements through development

¹⁷⁰ See Nira Wickramasinghe, *Sri Lanka in the Modern Age: A History of Contested Identities*, London: Hurst and Company, 2006, p. 235; and C.R. de Silva, ‘Education’, in *Sri Lanka: A Survey*, K.M. de Silva, (ed.), London: C. Hurst & Co., 1977, p. 412, for an analysis on the impact of the language policy in education in Sri Lanka.

¹⁷¹ Myrdal, *Asian Drama*, Vol. I, p. 358.

¹⁷² Masses were agitated over ethnic and religious issues and the politicians were interested in achieving broader goals of development.

plans, and the opposition political parties used development plans as the tools to criticise government policies when they failed to achieve targets. Eventually, the *Ten Year Plan* remained a mere piece of academic excellence, which was never implemented. After Mr S.W.R.D. Bandaranaike was assassinated, in 1962, his wife Mrs Sirima Bandaranaike took over the government and adopted a system of 'rolling plans' making planning a continuous process rather than being limited to a fixed plan running through a long period.¹⁷³

Mrs Bandaranaike's development plan was called *The Short-Term Implementation Programme* of 1962. It had described the *Ten Year Plan* as a 'perspective plan' or a kind of preparatory work.¹⁷⁴ However, I see *The Short-Term Implementation Programme* as an extension of the *Ten Year Plan*, in the way it has dealt with the population problem. By the early 1960s, the focus of national planning was two-fold: to reduce population growth and to increase the use of resources.¹⁷⁵ Keeping in line with the global family planning programme, Mrs Bandaranaike decided to integrate family planning with the Maternal and Child Health (MCH) Programme, and directed the Department of Health Services to arrange to further educate the public on family planning practices particularly in rural and estate areas.¹⁷⁶ Thus Sri Lanka accepted family planning as a national policy in 1965, and the Family Health Bureau (FHB) was set up in 1968 within the

¹⁷³ Myrdal, *Asian Drama*, Vol. I, p. 358.

¹⁷⁴ *The Short-Term Implementation Programme*, Colombo, Department of National Planning, 1962, p 39.

¹⁷⁵ Ibid., p 17.

¹⁷⁶ *Annual Report of the Family Planning Association 1969-70*, Colombo: FPA, pp. 4, 19.

Ministry of Health to carry out family planning activities.¹⁷⁷ With the integration of family planning and the MCH programme, the troubled population issue officially tied the knot with women's or rather mothers' health. Thus, the boundary between family planning and population control became rather fuzzy within official rhetoric, because the objective of both these initiatives converged to curb the population growth rate. This in turn confused policy makers in the 1960s in distinguishing between a family planning programme and a population policy. Further, by integrating family planning with the MCH programme, the population growth rate was successfully reduced without the formulation of an actual population policy.

The 1970s – Implementation Mode

This confusion was further emphasised in *The Five Year Plan* of 1972–76 because family planning activities carried out by the FHB were mentioned under the sub-heading of 'Population Policy'.¹⁷⁸ But when the government signed an agreement with the UNFPA in 1973 for eleven projects covering diverse areas of the population problem over a period of four years, population policy in Sri Lanka gained an all-encompassing meaning.¹⁷⁹ As part of the UNFPA project, a national

¹⁷⁷ De Silva, 'Population Planning Strategies', *Asian Profile*, p. 400.

¹⁷⁸ *The Five Year Plan, 1972–1976*, Ceylon: Ministry of Planning and Employment, 1971, p. 121.

¹⁷⁹ Wickrama Weerasooria, 'Pre-ICPD Activities on Population and Development in Sri Lanka (1977–1987),' in Bradman Weerakoon (ed.), *ICPD – '15 Years on' Sri Lanka*, Colombo: FPA, 2009, p. 1, (pp. 1–6). I have mentioned the areas covered by these eleven projects in the Introduction .

policy on family planning was declared by the government of Sri Lanka.¹⁸⁰ Under this agreement,

UNICEF, WHO, UNESCO and ILO assisted the Government to execute this programme, which dealt with a number of Ministries such as Ministry of Health, Justice, Education, Labour and Colombo Group of Hospitals. Population programmes were conducted also with the Janatha Estate Development Board, the State Plantations Corporation and Non-Governmental Organisations such as the FPA of Sri Lanka, Community Development Services, Population Services Sri Lanka and Sri Lanka Association for Voluntary Surgical Contraception.¹⁸¹

With these initiatives, the subject of population expanded into other fields apart from health, and was integrated as a core concept into the country's development project. In this way, population became the 'problem' of all the above mentioned ministries, and they all tried to tackle the problem within their purview. In view of this, a Steering Committee was set up in 1972 to co-ordinate and monitor the implementation of all population programmes that the project envisaged to implement.

The meaning of what is policy changes over time. Of course, it would be an overambitious venture to try to find a population policy in the modern sense within the planning discourse of post-independence Sri Lanka. From a historiographical viewpoint, it is only possible to chart the varying meanings of population policy, as it was interpreted by different people. Likewise, population policy had diverse meanings and connotations at different moments within the

¹⁸⁰ *Population and Family Planning Activities in Sri Lanka*, Colombo, Population Division, Ministry of Plan Implementation, 1979, p. 26.

¹⁸¹ *Public Investment, 1986–1990*, Colombo: National Planning Division, Ministry of Finance and Planning, 1986, p. 130.

development discourse. As I have mentioned above, population policy formulation was not a linear process, but it reacted to different development priorities and internal (ethnic, social and religious) issues that sprung up over the years, such as the youth uprising in 1971 and 1989, and the ethnic conflict in 1983. Surprisingly, despite these upheavals, Sri Lanka upheld its development model status especially with regards to women's health well into the 1990s.

I will provide a brief political history of post 1977 Sri Lanka to understand the distinct turn that took place in the trajectory of women's health in the 1990s.

Post-1977 – Open Economic Policy

Sri Lanka underwent a radical change in 1977 with the introduction of the open economic policy and a regime change from the socialist Sri Lanka Freedom Party (SLFP) to the capitalist United National Party (UNP). J.R. Jayawardena was elected as president with an overwhelming majority. Therefore, from 1977 to 1994, the UNP had an unprecedented ability to influence the framing and implementation of state policy. With this regime change, Sri Lanka departed radically from the state regulated, social welfare oriented and inward looking policies that characterised many post-colonial regimes. This radical departure meant policies of economic liberalisation with the aim of an increased economic growth.¹⁸²

Proclaiming to 'let the robber barons in', President Jayawardena (1977–88)

¹⁸² Newton Gunasinghe suggests that the open economy drawn by export-led growth can be linked to the ethnic tensions which culminated in 1983. See Newton Gunasinghe, 'The Open Economy & Its Impact on Ethnic Relations in Sri Lanka,' in *Sri Lanka The Ethnic Conflict: Myths, Realities & Perspectives*, Committee for Rational Development, New Delhi: Navrang, 1984, pp. 197–214.

collaborated with the International Monetary Fund (IMF), the World Bank and Western governments to introduce Structural Adjustment Policies (SAPs).¹⁸³ As Gunasinghe has written,

[i]n 1977, with the introduction of the open economic policy, most of the elements of the regulative mechanisms were dismantled. The system of quotas, permits, and licenses was abolished. The import-export trade was liberalized. ... The free health scheme was subverted, with doctors in government hospitals being granted the right to engage in private practice. The free education scheme was affected by teachers in the government schools being permitted to give private tuition.¹⁸⁴

The main stated aim of the SAPs was to make the economies of developing countries more market oriented by concentrating more on trade and production in order to boost their economies.¹⁸⁵ These policy reforms (also referred to as neo-liberal initiatives) advocated by the World Bank and the IMF were introduced to Sri Lanka in 1989 by the ruling UNP and were continued by the Peoples' Alliance (PA) government elected in 1994.¹⁸⁶ The second wave of SAPs in the 1990s reorganised conventional welfare by promoting 'privatisation of the public sector and liberalisation of the economy,' which in turn affected the state's long held

¹⁸³ Neil de Votta, 'Politics and governance in post-independent Sri Lanka,' in Paul R. Brass (ed.), *Routledge Handbook of South Asian Politics: India, Pakistan, Bangladesh, Sri Lanka and Nepal* London/New York: Routledge, 2010, p. 121.

¹⁸⁴ Newton Gunasinghe, 'The Open Economy and Its Impact on Ethnic Relations,' in Deborah Winslow and Michael Woost (eds), *Economy, Culture, and Civil War in Sri Lanka*, Bloomington and Indianapolis: Indiana University Press, 2004, p. 101.

¹⁸⁵ W.D. Lakshman, 'Introduction,' in W.D. Lakshman (ed.), *Dilemmas of Development: Fifty Years of Economic Change in Sri Lanka*, Colombo: Sri Lanka Association of Economists, 1997, p. 10.

¹⁸⁶ Ibid.

patriarchal image as the 'provider' for its citizens.¹⁸⁷ For this some criticised the state for not keeping citizens' welfare in the focus.

However, this new liberal policy environment attracted the investment of large multinational companies in Sri Lanka.¹⁸⁸ Adhering to the Women in Development (WID) approach that characterised many development initiatives of the early 1970s, women were integrated into development projects. The Sri Lankan government conceptualised the opening of the Export Processing Zone/Free Trade Zone in Katunayake as part of the national economic plan to make use of female labour spread across rural areas. By recruiting women to work in export processing zones, especially at garment factories, and providing domestic labour to the oil rich Middle Eastern countries as female migrant workers, Sri Lanka adopted the WID approach. With the open economy, women's labour became the backbone of the foreign income structure in Sri Lanka. By 1986, Sri Lanka's share of industrial exports overtook agricultural exports due to growth in the garment industry.¹⁸⁹ By 1992, Sri Lanka's garment industry overtook tea exports to become the largest foreign exchange earner in the country (US\$ 400

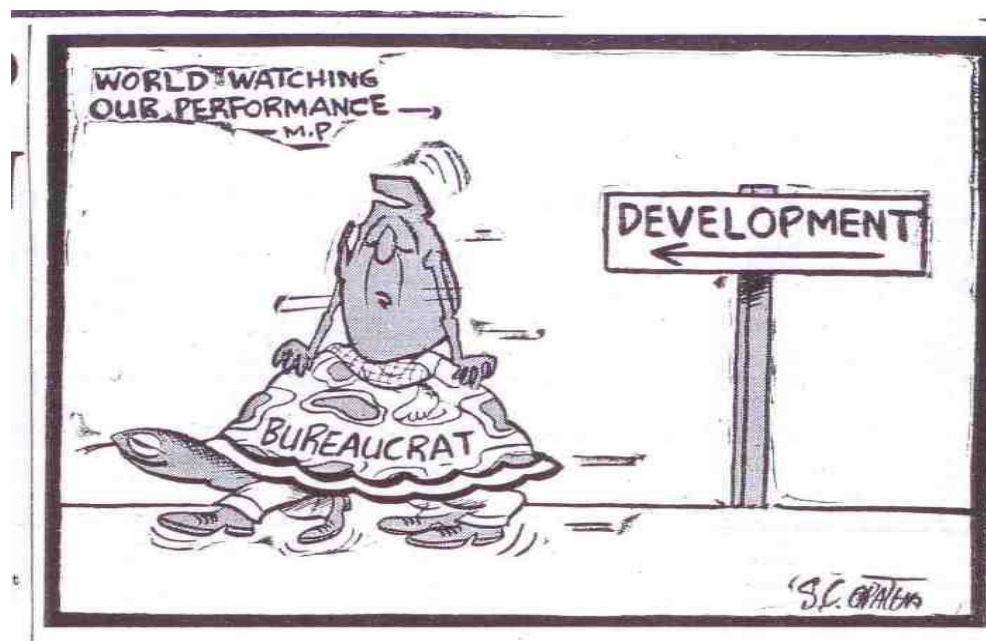
¹⁸⁷ Kanchana Ruwanpura, Chandra Rodrigo, et al., *Structural Adjustment, Gender and Employment: The Sri Lankan Experience*, Geneva: ILO, 2000, p. 3.

¹⁸⁸ The first Export Processing Zone or Free Trade Zone was set up in a complex of 500 acres adjacent to the Katunayake International Airport in 1978 in order to encourage export-led industrialisation which attracted foreign direct investments and domestic entrepreneurs due to various tax concessions. See Saman Kelegama, *Development Under Stress: Sri Lankan Economy in Transition*, Colombo: Institute of Policy Studies, 2006, p. 52, and *Public Investment, 1979–1983*, Colombo: Ministry of Finance and Planning, 1984, p. 56.

¹⁸⁹ Godfrey Gunatilake, 'Development Policy Regimes,' in W.D. Lakshman and Clement A. Tisdell (eds), *Sri Lanka's Development Since Independence: Socio-economic perspectives and Analysis*, New York: Nova Science Publishers, 2000, p. 147.

million).¹⁹⁰ International media soon dubbed Sri Lanka ‘the new investment centre of Asia.’¹⁹¹

With the implementation of these dynamic development projects, people lost faith and confidence in planning and policy making by the late 1970s. According to the newspapers of the day, planning seemed purely an academic venture. An article of *The Ceylon Daily News* criticised the planning process as a waste of time and resources, and suggested a programme of action instead. The article also stated: ‘Planning was not writing books. As far as Sri Lanka was concerned that had been the case. The plans had become like theses for post-graduate qualifications.’¹⁹²



¹⁹⁰ Saman Kelegama, ‘Ready-Made Garment Industry in Sri Lanka: Preparing to Face the Global Challenges,’ in *Asia-Pacific Trade and Investment Review*, Vol. 1, No. 1 (April 2005), p. 53; and W.D. Lakshman, ‘Economic Development and Sociopolitical Change in Sri Lanka,’ in Paul R. Brass (ed.), *Routledge Handbook of South Asian Politics: India, Pakistan, Bangladesh, Sri Lanka and Nepal*, London/New York, Routledge, 2010, p. 340.

¹⁹¹ Kelegama, *Development Under Stress*, p. 53.

¹⁹² ‘Planning Ministry bureaucrats under fire’ in *The Ceylon Daily News*, 1977 Oct. 20 (Thursday), p. 3.

This cartoon, published in one of the well distributed English dailies of Sri Lanka, is a classic example of the weariness with development planning after almost three decades of futile planning.¹⁹³ After 1977, came a new, dynamic era with an emphasis on implementation and action, rather than planning and theorising. Comprehensive policy was not needed, but policy measures which could be implemented directly and effectively were regarded as the need of the hour. This was attested by the secretary to the Ministry of Plan Implementation in the late 1970s, when I interviewed him on the history of population policy formulation in Sri Lanka. He said that during his tenure (1977–87) he never genuinely wanted to formulate a population policy. In fact, he saw it as a waste of time and resources, instead he believed in the actual act of implementing. He also questioned me (in a rather cynical manner) on the use of a policy document.

No. I never believed in policy documents, because if I have come up with one, university academics and legal people [would] try and find loopholes in it and criticise that; nothing will happen in real terms. Policy making is a real waste of time and also the worst thing to do as an administrator. My approach was to do daring things, so I concentrated on implementation and I had a wonderful staff, really committed, and I had the backing of the executive president so I did what I thought was right and appropriate. Have you heard of Macaulay's words, "For Forms of Government let fools contest; whatever is best administered is best"; that was my policy and that is what I believe.¹⁹⁴

He further stated that

¹⁹³ S.C. Opatha, Cartoon in the *Daily Mirror*, 21 August (Monday) p. 4.

¹⁹⁴ Interview with the retired secretary to the Ministry of Plan Implementation in the late 1970s, on 7 August 2011 at his office in Colombo. (The quote from Alexander Pope not Macaulay.)

[I] amended the government gazette bringing more subjects under my Ministry – one being “the formulation and implementation of population policy.” This one sentence was the key to all I thereafter did in the field. It was like a magic wand. With that one sentence no one doubted what our Ministry did or could do or our authority to do it.¹⁹⁵

Even though he was not genuinely interested in formulating a population policy he used that one particular sentence he added to the government gazette to implement population policy measures such as sterilisation incentives, putting family planning above party politics, establishing the Population Division and Population Information Centre at the Ministry of Plan Implementation, the funding of social marketing programmes for contraceptives and getting Ayurvedic practitioners trained and involved in family planning.¹⁹⁶ The post-1977 era was a period of dynamically implemented projects and programmes aimed at achieving ‘development’ of which population control was one of the main components.

In any case, this dynamic implementation mode was not without its shortcomings. Initially family planning was the responsibility of the Ministry of Health and was implemented by the Family Health Bureau, but by now, because of the UNFPA initiative, population is not the responsibility of any ministry, rather it has become the responsibility of all the above mentioned ministries.¹⁹⁷ Thus by the mid-1980s there appeared a rift between the Ministry of Health and the Ministry of Plan Implementation regarding whose purview family planning

¹⁹⁵ Weerasooria, ‘Pre ICPD Activities on Population’, p. 2.

¹⁹⁶ Ibid., p. 3.

¹⁹⁷ *The Report of National Workshop on Population Information Exchange & Resource Development in Sri Lanka*, Colombo, 1980, p. 23.

should come under. The Ministry of Health claimed that family planning was traditionally a matter of medical expertise and intervention by the Ministry of Plan Implementation should be limited to 'non-medical, non-health population matters.'¹⁹⁸ However, the secretary of the Ministry of Plan Implementation in the late 1970s sees the intrusion of the Ministry of Health into the field of population and family planning as a coup against him. Keeping in mind the broader picture of Sri Lanka's development-plan implementation, I see this not as a rift, but as the strengthening of the link between women's health, population and development. Due to the mode of dynamic implementation undertaken by the state, population had to be carefully planned. Population became a women's health concern as well as a development concern strengthening the link between women's health, population and development. However, the outcome was the erasure of the possibility of developing a comprehensive approach to women's health. Women's ability to reproduce became a problem to the state and as a consequence, reproduction became synonymous with women's health.

At this point, it is necessary to provide a brief account of the economic, political and governmental context of 1990s Sri Lanka to understand the disconnect (which I will discuss in the fourth and the fifth chapters) that emerged between the way the state framed the discourse on woman's body and the international women's health agenda in the 1990s.

¹⁹⁸ Weerasooria, 'Pre ICPD Activities on Population', p. 5, (pp. 1–6).

The 1990s – The Turbulent Decade

Although, the UN General Assembly proclaimed the 1990s as the ‘Fourth United Nations Development Decade’, for Sri Lanka the 1990s was a decade of economic and political turbulence.¹⁹⁹ In the 1990s, the Sri Lankan state faced three major challenges. The first came in the shape of an economic crisis with the onslaught of the second phase of SAPs in 1989. The second came as military challenges in the form of the *Janatha Vimukthi Peramuna* (JVP – Peoples’ Liberation Movement) uprising (1989–91) in the south and the violent ethnic conflict with Tamil separatists (1983–2009) in the north and east of Sri Lanka. The third came in the form of political challenges when the Peoples’ Alliance (PA) overthrew the seventeen-year rule of the United National Party (UNP) (1977–94).

Economic, Military and Political Milieu of the 1990s

Despite the criticism it elicited, the liberalisation exercise continued with the second phase of SAPs with the blessing of President Ranasinghe Premadasa elected by the UNP in 1989. This was largely accomplished by strategically deploying women’s labour.²⁰⁰ Contrary to expectations, the budget deficit increased to 7.5 percent of the GDP in the 1990s, due to escalating defence expenditures and non-

¹⁹⁹ http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/45/199 (Accessed on 26 September 2012).

²⁰⁰ According to Kelegama, Premadasa’s economic policy was characterised by three main policy decisions. First, export oriented industrialisation was further promoted by launching 200 rural garment factories. Secondly, he renamed privatisation as ‘peopleisation’, in the hope of gaining workers’ support by conferring broad-based ownership to the public. Thirdly, the programme of *Janasaviya* (People’s Strength), a poverty alleviation programme that address the needs of the rural poor and the urban working class. Kelegama, *Development Under Stress*, p. 59–62

bank borrowings. This situation further worsened when Sri Lanka's private sector lobbied for tax concessions. This pushed the state to come up with ad hoc policy-making, which in the end led to allegations of cronyism.²⁰¹

In 1994, the People's Alliance (PA) came into power with Chandrika Kumaratunge as president, aided by the election slogan 'Market policy with a human face'. The new government broadly continued policies of liberalisation. The PA introduced several big service-oriented ventures privatising the gas, telecom, and airline services.²⁰²

During the rule of both the UNP and the PA, liberalisation of the economy continued with the setting up of 200 rural garment factories, and encouraging women to seek employment in the Gulf countries as housemaids. Yet the state mobilised women's labour without emancipating them from the patriarchal structure or empowering them to challenge it themselves. Instead, the state strategically used longstanding, widespread ideas of Sri Lankan, Sinhalese womanhood such as the feminine qualities of nimble fingers and docile, disciplined bodies. In other words, the state deployed women's bodies keeping them within their traditional roles to fill its own coffers.

Broadly speaking, up until 1990s the international development and population control agenda and women's health agenda of Sri Lanka were although not identical, mutually intelligible. However, by the mid 1990s, a tension could be seen developing between achieving demographic targets (replacement level

²⁰¹ Ibid.

²⁰² Ibid., p. 56.

fertility) and the need for the militarised Sri Lankan state to access women's bodies for political and economic ends.²⁰³ According to renowned demographers Langford and de Silva, by 1994, Sri Lanka reached replacement-level fertility six years ahead of the target predicted by the United Nations' medium variant population projections prepared in 1990.²⁰⁴ This means in demographic parlance that, by 1994, Sri Lanka was ready to shift from a 'controlled and planned' women's health ideology to the reproductive health and rights paradigm proposed at the ICPD in 1994, though this never materialised.

In the 1990s, the Sri Lankan state mobilised the discourse on woman's body embedded in traditional socio-cultural reproductive roles to cater for the economic and political commitments of the state fashioned by the second phase of SAPs and the militarisation of ethnic conflict. The state's deployment of the discourse on woman's body did not make space for the shift to the reproductive health and rights paradigm in the sphere of women's health. When the ICPD agenda proposed to look at women's health 'beyond reproduction' by advocating reproductive health and rights the state continued to frame the discourse on woman's body within a social reproductive role as nurturers of the community

²⁰³ Replacement level fertility means having 2.1 children per woman. This value stands for the average number of children a woman would need to have to reproduce herself by bearing a daughter who survives to childbearing age. If replacement-level fertility is sustained over a sufficiently long period, each generation will exactly replace itself in the absence of migration. (http://www.un.org/esa/sustdev/natlinfo/indicators/methodology_sheets/demographics/total_fertility_rate.pdf - Accessed on 26 October 2012).

²⁰⁴ C.M. Langford, 'Fertility Decline in Sri Lanka: Could Fertility Now Be at about Replacement Level?' in Zeba Satha and James Phillips (eds), *Fertility Transition in South Asia*, (Oxford: Oxford University Press, 2001), p. 131, and I. de Silva, 'Age at Marriage in Sri Lanka: Stabilising or Declining?' *Journal of Biosocial Science*, Vol. 22, No. 4 (1990), p. 403.

and nation and disseminators of tradition and culture in order to face the turbulent political situation of the 1990s. Due to the conflict of interest, it seemed that the state was not ready to accommodate the new ideology of women's health 'beyond reproduction' proposed at the ICPD and introduced to Sri Lanka through the island wide Well Woman Clinic programme (WWC) in 1996.

Women's Health in Official Rhetoric

From the very beginning in the 1950s, women's health came under the maternal and child health section of development plans. This implies that women were seen only as mothers whose main responsibility was to give birth to healthy children who could shoulder the development programmes of the country. Women were idealised as mothers of the nation state and their prime duty was designated as social and biological reproduction. In agreement with this, Jayaweera and Sanmugam pointed out in 1995 that

[h]ealth and nutrition programmes have focused hitherto on the woman as a mother, in her reproductive role and as the care giver in the household. It is necessary that the entire life cycle of the woman be considered without respect to marital status. The mother and child syndrome has to be replaced by a holistic approach that includes the multiple roles of women and the health and nutritional needs of the adolescent girl, the single woman, the childless mother, the working woman and the ageing woman, especially as women in Sri Lanka are projected to live longer than men the lacunae in the provision of services to these categories need to be addressed.²⁰⁵

²⁰⁵ Jayaweera, S. and Sanmugam, T. *Addressing Poverty Reduction and Women in Development through Human Resource Development*, Colombo: CENWOR, 1995, p. 67.

In addition, in the early 1970s, a new term ‘family health’ was introduced which addressed the need to inculcate knowledge on nutrition, immunisation, health education, environmental health and family planning.²⁰⁶ Moreover, by 1981, the population growth rate had come down to 1.7 percent per annum, thus population was not seen as a ‘problem’ anymore within official rhetoric.²⁰⁷ After this the dynamic secretary of the Ministry of Plan Implementation resigned from his post in 1987, and the vigour of programme implementation had ebbed.²⁰⁸

In contrast to the population control measures taken in response to seeing population as a grave problem in the 1970, by the 1990s, the international arena advocated a new women’s health concept. Instead of simply providing knowledge, medical and technical assistance and subtle coercion for population control, Sri Lanka formulated the Population and Reproductive Health Policy in 1998 as a consequence of the ICPD held in Cairo, in 1994. The government Well Woman Clinic (WWC) programme was launched in 1996 to screen women for common non-communicable diseases. The WWC programme suggested a shift in the way women’s health was looked at: from ‘controlling and planning’ to a more comprehensive approach.²⁰⁹

While I consider this shift laudable for its innovative approach, population policy measures are silent about women’s bodies and reproductive rights. Through

²⁰⁶ *Development 1931–1981 Sri Lanka*, Colombo, Ministry of Plan Implementation, 1981, p. 117.

²⁰⁷ *Public Investment 1981–1985*, Colombo, Ministry of Finance and Planning, 1981, p 31.

²⁰⁸ Interview with the former Director of the Population division of the FHB, Colombo, 10 August 2011 at his new office in Colombo.

²⁰⁹ The WWC programme and the Population and Reproductive Health policy are analysed in greater detail in the fifth chapter of my thesis.

all these measures, population underwent a scrutinised surveillance process. In effect the surveillance process was carried out through women's bodies, because these policy measures ensured the careful 'controlling and planning' of women's reproduction in order to service the state building project of independent Sri Lanka.

Concluding Thoughts

Sri Lanka marked its grand debut in the 1970s, appearing on the demographic map of the world as the 'development model' for South Asia due to low fertility and mortality rates, high female literacy levels, women's empowerment and a sound public health care. Even though Sri Lanka managed to control its population growth rate in a remarkable manner, reaching replacement level fertility by 1994, it failed to achieve development even after four decades. What went wrong in the development process? Since, population is one of the main determinants of development, women's health emerged as the main indicator of development in the state building project of Sri Lanka. It is necessary to interrogate this 'model' status and unravel the intricate relationship between population and development which has been woven neatly into women's health discourse.

Renowned local economists, demographers and policy makers believed in this 'model' status unquestioningly since it was put forward by international demographers who compared the demographic trends of Sri Lanka with those of Europe. I challenge the 'model' status for not being able to deliver the promised

development and for limiting women's health to reproduction by silencing women's bodies and reproductive rights. My challenge is not based on population growth rates, trends and projections, but on the perceptions, theories and ideals of population within the official rhetoric. Through a careful reading of census reports and development plans of post independence Sri Lanka and through interviews with key policy makers of the time I have illustrated how population first became a 'question' then a 'problem', and how implicit coercive policy measures were put forward (instead of formulating a population policy document) to reduce the population growth rate. I read this 'delay' in population policy-making not as a bona fide mistake done within the official quarter, but as the silencing of women's bodies and reproductive rights by the state in the aim of becoming a development 'model' for South Asia.

After charting the social and political context of the 'development model' in South Asia, the next chapter gives a historical account of the family planning programme of Sri Lanka.

Chapter Two

A History of Family Planning and Population Control in Sri Lanka (From the 1930s to the 1980s)

Abstract

With the granting of universal adult suffrage in 1931, women's position in colonial Sri Lanka became relatively advanced compared to other countries in the region. As part of this story a group of well-educated, upper class women from Colombo established the Family Planning Association of Ceylon (FPA) in 1953 as a social welfare project with the aim of improving the living standards of the poor.²¹⁰ According to the pioneers of the FPA, family planning in Sri Lanka started as an altruistic venture to improve the lives of poor and destitute women. At the same time, social work provided the only respectable opportunity for upper class women to step out from their traditional private domain. By the 1950s, through programmes like family planning and the role assumed by upper class women, women's health and bodies became interpellated into a 'controlled and planned' ideology. In hindsight, this interpellation appears to be the basis to Sri Lanka's claim to a 'developmental modernity'. In this trajectory towards development, women's health became a 'controlled and planned' project of the public health system both institutionally and ideologically.

This chapter charts the institutional history of family planning in Sri Lanka. It tells the overlapping stories of early family planning efforts in the 1930s, the beginnings of the FPA in the 1950s, the global politics of funding family planning programmes in the 1960s, and the Sri Lankan state's embrace of family planning and international funding in the 1970s and 1980s. In doing so, this chapter shows how the ideology of population control replaced the maternalist welfare ideology in Sri Lanka by the 1970s and became the official ideology on women's health by the 1980s.

²¹⁰ Although, my project is about the family planning programme of Sri Lanka, most of the early sources on family planning, from the 1950s, are the records of the Family Planning Association (FPA) which was established as an NGO in 1953. The government adopted family planning in 1965 with the establishment of the Family Health Bureau (FHB), but the FPA still retains its autonomy as the pioneer NGO in reproductive health in Sri Lanka.

Introduction

This chapter traces the career of family planning in Sri Lanka—from its pre-history of the fragmented birth control movement under colonialism to the re-branding of family planning as ‘reproductive health’ after the International Conference on Population and Development (ICPD). Although, the history of family planning in Sri Lanka resembles much of the careers of family planning programmes undertaken in other countries during the same period, it does have a number of particular aspects.

One such example is the distant relationship the state maintained with the concept of family planning until the mid-1960s (almost one and a half decades after the FPA was established). As mentioned in chapter one, during the 1950s, Sri Lanka came under the ‘radar’ of the global population establishment as a social laboratory aiding global research on population and contraceptives.²¹¹ By the 1970s, this ‘population laboratory’ became a ‘development model’ for South Asia due to its low fertility and mortality levels, increasing life expectancy, high women’s literacy rate and sound public health services.²¹² The trajectory of the family planning programme of Sri Lanka both reflects and forms part of the project of family planning across the world during the twentieth century.

²¹¹ Agreeing with Taeuber’s ideas about Sri Lanka, Prof Bryce Ryan wrote to Dr M.C. Balfour, officer of the Rockefeller Foundation, that ‘Ceylon is ideal for a population analysis laboratory.’ In the mid-1940s, the Rockefeller Foundation began a period of assessment into its future role in health, which culminated in the formation of the Division of Medicine and Public Health in 1951. Rockefeller Collection, Record Group 1.1/462, Box 1, Folder 2. Letter from Prof Bryce Ryan to Dr M.C. Balfour of the Rockefeller Foundation, 18 January 1950.

²¹² I have quoted works of Kirk (1969), Myrdal (1968) and others in the Introduction on this point.

This chapter seeks to understand the career of such concepts as eugenics, birth control, population control, family planning and reproductive health within the family planning programme of Sri Lanka.²¹³ Even though these terms have a distinct meaning within the global politics of population control, they have acquired different connotations in the context of the Sri Lankan family planning programme. The term population control is used throughout, despite the worldwide shift in terminology from birth control to population control, and from family planning to reproductive health.²¹⁴ During my fieldwork it became obvious to me that demographers, medical/health professionals and policy makers of Sri Lanka did not and still do not make an attempt to take cognizance of this shift and its implications at the policy-making level. I argue that policy makers' uncritical and unstinted belief in neo-Malthusian population control ideology made them disregard the logic of this terminology shift. In fact, policy makers take these shifts for granted.

In contrast, the eminent scholar Vandana Shiva, when studying the Indian context, claims that this terminology shift has not been an innocent process but a political one with a capitalist agenda. She points out that although the contraceptives pushed through these programmes may not be safe for women,

²¹³ See Linda Gordon (1976), Betsy Hartmann (1987), Matthew Connelly (2003), Alison Bashford (2007, 2010) and Sarah Hodges (2010) for the history and politics of global population control.

²¹⁴ When I presented a paper titled 'Well-Woman Clinics: Shift in Women's Health in Sri Lanka' at the Population Association of Sri Lanka on 17 August 2011, a renowned professor of demography at the University of Colombo agreed that such terminology shift would be the last thing to come to mind for policy makers and demographers, since population control is taken as the ultimate goal in women's health.

they are disguised by the empathetic notion of 'safe motherhood'.²¹⁵ However, Sri Lanka does not have any claims to such analytical work on women's health policies or issues. Even though I focus on the history of the family planning programme in Sri Lanka in this chapter, it remains more or less an institutional history. Focusing on this terminology shift helps to understand how the family planning programme in Sri Lanka embedded itself in the global population studies establishment.

The first section of this chapter places Sri Lanka within the global population discourse. The second section explores the development of the family planning programme in Sri Lanka and how it was dealt with by the government and how it relates to the larger ethnic and political issues of the country. The first subsection looks at the establishment of the FPA in the 1950s. This includes an account of the early family planning efforts in the 1930s, the introduction of the pioneers of the FPA, and the politics of funding family planning programmes during the 1950s.

In the second part of the chapter, I trace the developments of the family planning programme in Sri Lanka from the late 1950s to 1980s. I describe how the state's 'planning ideology' in the late 1950s, 'experimental mode' of the 1960s and 'implementation mode' of the late 1970s affected the family planning programme. By doing so, I point out the vexed connection between women's health and the discourses on woman's body in post-independence Sri Lanka.

²¹⁵ <http://www.iisd.ca/Cairo/wfslegac.txt> (Accessed on 18 May 2013).

Dr Mary Rutnam and Early Efforts of Family Planning in Sri Lanka

The first documented, organised attempt at birth control in Sri Lanka started in 1937 when the Canadian born Dr Mary Rutnam opened a birth control clinic in Sri Lanka's capital city, Colombo.²¹⁶ She was inspired by fellow Canadian doctors Dr C. Oliver and Dr Margaret O'Hara engaged in social reform and welfare activities in early twentieth century India. The India based Dr Oliver's visit to Colombo in 1904 persuaded Dr Rutnam to subscribe to British, American and Canadian journals to widen her knowledge about contemporary trends and developments in the West. This impacted her social work.²¹⁷ Thus, the family planning programme in Sri Lanka, as elsewhere across the globe, started as a birth control clinic. The middle class women of the colonised bourgeoisie worked and copied the role of these white, imperial women. To put Rutnam's social work and other efforts at birth control, family planning and women's health in context, I will sketch the brief colonial history of Sri Lanka.

Sri Lanka was under Western colonial rule for nearly four centuries until independence was granted by the British in 1948. The Portuguese (1505–1656) and the Dutch (1656–1796) held only coastal areas, but the British ruled over the entire island from 1815 to 1948. By the 1900s, in order to facilitate the tea plantation economy, railways, roads and harbours were developed by the British

²¹⁶ Abhayaratne and Jayawardena, *Family Planning*, p. 2.

²¹⁷ Jayawardena, *Dr. Mary Rutnam*, p. 16.

government.²¹⁸ Simultaneously, a new social consciousness among the colonised developed. Due to the tea plantation economy and increased educational facilities, an urban and a rural petty bourgeoisie class came into shape by the late nineteenth century.²¹⁹ Following India's lead, in 1919 the Ceylon National Congress was formed. Other mass social movements included the Social Service League, founded in 1915, that addressed health issues and promoted welfare thinking.²²⁰

Influenced by British, American and Canadian women's rights advocates, and taking the example of Indian women activists, a group of Sri Lankan middle class, Western-educated women came together to fight for women's rights and social reform. The Women's Franchise Union was formed in 1927 by a group of Sri Lankan professional women, many of whom were wives of nationalist and labour party leaders. The first meeting of the Women's Franchise Union was presided over by Lady Dias Bandaranaike (mother of S.W.R.D. Bandaranaike, Sri Lanka's Prime Minister from 1956 to 1959).²²¹ These pioneering women, members of these social and political movements were doctors, teachers and lawyers. As mentioned in the Introduction Sri Lankan women had the opportunity of school education provided by Baptist and Methodist missionaries at the American Mission and the Church Missionary Society from the 1820s. By the early 1900s, there was a

²¹⁸ According to the *Ferguson's Ceylon Directory*, by 1921 1,093,000 acres were under plantation while 798,000 acres were used to grow rice.

²¹⁹ See Kumari Jayawardene's *Nobodies to Somebodies* (2000), Michael Roberts (1979) and Arnold Wright (1999) for the social and economic transformations of the colonial and post-colonial era.

²²⁰ Jayawardena, *Dr. Mary Rutnam*, p. 14.

²²¹ Jayawardena, *Feminism and Nationalism*, p. 128.

significant number of qualified upper class women in Sri Lanka eager to engage in social work.

Such was the milieu when Dr Mary Rutnam started her social work in Colombo. Having failed to find employment at mission hospitals—despite being a qualified gynaecologist—because of her unconventional marriage to a Sri Lankan Tamil, Dr Rutnam took up a temporary job at the Lady Havelock Hospital for Women and Children in Colombo.²²² Rutnam set up the Girls' Friendly Society in 1904 to create a space for young women where they could meet and discuss their problems. The Ceylon Women's Union was formed in the same year, and Rutnam used its venue to introduce local women to recent advances in maternal health, child care, nursing and education.²²³ Rutnam addressed the issues of health and hygiene through writing *A Health Manual for Schools* (1923), which was translated to Sinhalese and Tamil and used as a school text book for several decades.²²⁴ Her untiring efforts to educate women on health and hygiene had the flavour of a 'civilising mission'. In the preface to the book *Homecraft Manual for Ceylon Schools* published in 1933, she wrote, 'Simplicity, orderliness, thrift and scrupulous cleanliness are the lessons that should be taught ... for these are the essentials of good housekeeping in the homes of rich and poor.'²²⁵ Ideas and concepts of cleanliness, orderliness and thriftiness as the objectives of girls'

²²² The Lady Havelock Hospital for Women and Children was established in 1895 in Borella, (Colombo 8) and changed its name to Lady Ridgeway Hospital for Women and Children in 1910.

²²³ Jayawardena, *Feminism and Nationalism*, p. 121.

²²⁴ Ibid., p. 21.

²²⁵ Ibid.

education fitted well into the existing missionary education system of the colonies. Since at least from 1927, Rutnam made clear her disappointment with government facilities for women, especially at the government maternity hospital in Colombo. By 1930, through social service activities the Ceylon Women's Union reached out to rural women, too, and changed its name to *Lanka Mahila Samiti* (Lanka Women's Society). In 1932, Rutnam was unsuccessful in her attempt to persuade the Ceylon Medical Council to include birth control and eugenics in the curriculum of the Ceylon Medical College. In 1935, Edith How-Martyn, a close associate of Margaret Sanger, visited Colombo on her world tour for birth control. In 1937, following How-Martyn's lectures delivered in front of doctors and social workers, and after receiving a donation of £100 from a benefactor, Rutnam opened a birth control clinic in the Milk Feeding Centre of the Ceylon Social Services League in Colombo.²²⁶ This supplemented the birth control advice she had already been providing to middle class women at her nursing home on Havelock Road, in a well-to-do neighbourhood in Colombo.²²⁷ The clinic functioned for two years until the events of the Second World War intervened and the colonial government took over. There were no further attempts to provide birth control advice to the general public until after the Second World War and the country's formal independence in 1948.

²²⁶ Abhayaratne and Jayawardene, *Family Planning*, p. 2.

²²⁷ *Ibid.*, p. 22

Establishing the Family Planning Association of Ceylon – 1953

In 1952, Margaret Sanger, Dr Abraham Stone and Mrs Dorothy Brush visited Sri Lanka on their way back from the World Conference on Planned Parenthood in Bombay.²²⁸ Their visit and support inspired women activists of Sri Lanka to establish the Family Planning Association (FPA) of Ceylon in 1953. At the inauguration of the FPA on 15 January 1953, in recognition of her efforts towards improving women's health in Sri Lanka, Dr Rutnam was appointed as the first president of the FPA (although she had retired from medical practice in 1944). The tea party that followed was attended by doctors, social workers and members of the All Ceylon Women's Conference (ACWC).²²⁹ According to Mrs Sylvia Fernando, the hostess of the tea party and founding-secretary of the FPA, family planning in Sri Lanka was

from the beginning ... a relief to individuals – relief through contraception for overburdened incomes, overcrowded homes, malnourished children and physically exhausted mothers in slum and village.²³⁰

²²⁸ *Annual Report of the Family Planning Association on Ceylon 1969–70*, Colombo, FPA, 1971, p. 3. http://en.wikipedia.org/wiki/International_Planned_Parenthood_Federation (Accessed on 27 Dec. 2010).

²²⁹ Inaugural meeting was attended by Dr (Mrs) L.O. Abeyaratne (second president of the FPA), Prof O.E.R. Abhayaratne (professor of Public Health, University of Colombo), Dr (Mrs) F.R. Ram Aluwihare, Dr. C and Mrs. Amirthalingam, Mrs Ezlynn Deraniyagala (president of the All Ceylon Women's Conference), Prof C.C. de Silva, Dr A.F. Outschoorn (took up a WHO position soon after), Dr Mary Rutnam, Dr P.R. Thiagarajah (senior obstetrician at the De Soysa Maternity Hospital and Mrs E.C. Fernando (founding-secretary of the FPA until she retired in 1970). Colombo was the country's capital till 1977; today it remains the commercial capital of Sri Lanka.

²³⁰ C.C. de Silva (ed.), *A History of Family Planning in Sri Lanka 1953–1978*, Silvery Jubilee Souvenir of The Family Planning Association of Sri Lanka, Colombo, 1979, p. 7.

In other words, the FPA took up the project that had been interrupted by the Second World War, which seemed an important development need of independent Sri Lanka.

Fernando also came from a background of service to poor women. She was involved in social work through the All Ceylon Women's Conference (ACWC) and the Social Service League. In these organisations she helped poor and destitute women improve their living conditions. Through the ACWC, she attended conferences abroad and had the opportunity to meet and listen to such pioneers of the American family planning movement as Margaret Sanger, Dorothy Brush, Dr Abraham Stone and Clarence Gamble.²³¹ Family planning as a social welfare venture was indeed new to Sri Lanka in the 1950s, though, it goes without saying, Sri Lankan women had been attempting to control their fertility even before. Already in the 1940s, there were adverts about regulating reproduction, contraception and abortion in Sinhalese newspapers. Some of these adverts were placed by Ayurvedic physicians and some were simply marketed as help to 'women in need'.²³²

When the first FPA family planning clinic was opened at the De Soysa Hospital for Women in Colombo in September 1953, it was aptly called the 'Mothers' Welfare Clinic'. Newspapers announced: 'A Mothers' Clinic will be held

²³¹ Perdita Huston, *The Right to Choose, Pioneers in Women's Health and Family Planning*, London, Earthscan Publications Ltd. in association with the IPPF, 1992, p. 41.

²³² Advertisement, 'Daruduka', (Feeling sad about infertility), *Dinamina*, 25 May (Tuesday), 1948, p. 8.

every Wednesday afternoon from 2–4.30pm at the De Soysa Maternity Hospital where advice will be given to childless couples and on family planning.’²³³ According to one of the founder-members of the FPA, Dr Aluvihare, the order of the words in this press release were decided after much deliberation so as to avoid eliciting scorn by highlighting the main feature of the clinic which was family planning.²³⁴ By February 1954, there were 300 clients on the roster of the family planning clinic at the De Soysa Maternity Hospital.

Another early FPA member pointed out that family planning was regarded a ‘dirty word’ during the 1950s.²³⁵ The elite founders of the FPA perceived family planning as helping the poor and destitute,²³⁶ their work could be best described as altruistic welfare. However, throughout the history of family planning in Sri Lanka, concepts such as eugenics, birth control and family planning were all intertwined rather than distinct in the programme. The boundaries of these concepts were and still are rather blurred. Social service was the best and most respectable avenue in the 1950s for upper class women to step out of their domestic domain and enter into the public sphere. Family planning provided an opportunity for well-educated women, while at the same time they perceived family planning as a noble endeavour to help destitute women improve their life

²³³ ‘Reminiscences of Dr. Florence Ram Aluvihare one of the pioneers of the FPA of SL,’ in de Silva (ed.), *A History of Family Planning*, p. 21.

²³⁴ Ibid., p. 21. See also Siva Chinnatamby, ‘Perspective in Safe Motherhood Over the Past Four Decades’ a paper presented at the inter-regional meeting on safe motherhood, UNICEF, Colombo, 1992, p. 5.

²³⁵ ‘Family Planning the only way’, *The Ceylon Observer* (Sunday Morning Edition), 7 February, 1954, p. 7, and Huston, *The Right to Choose*, p. 43.

²³⁶ De Silva (ed.), *A History of Family Planning*, p. 7.

conditions. Accordingly, the slogans in the 1950s were 'Small families have less problems,' and 'Children of choice, and not by chance'.²³⁷

Despite the generally perceived need, in January 1953 (just before the inauguration of the FPA), the president of the All Ceylon's Women Congress (ACWC), Mrs Ezlynn Deraniyagala, plainly refused to include family planning in the ACWC agenda. She expressed this in *The Ceylon Observer*:

The General committee is aware that our membership represents every type of opinion, has always felt that there was more than sufficient work to be done on non-controversial issues, and that subjects like family planning could best be pursued by those interested in them, either individually or through some other appropriate organisation.²³⁸

Mrs Deraniyagala attended the inaugural meeting of the FPA (held in the form of a tea party at Mrs Fernando's residence), but expressed her abhorrence in taking up family planning since it was a controversial issue. She also felt that there are other areas that ACWC should concentrate on to improve the health sector of the country. The Sri Lankan government spent much on eradicating tuberculosis in the early 1950s and Mrs Deraniyagala saw 'sterilisation and termination of pregnancy' as the need of the hour rather than family planning. She explained that it is a waste of money to spend on infected, diseased and weak infants who will face an early death. She suggested sterilisation of 'diseased ignorant women'.

²³⁷ Ibid., p. 13.

²³⁸ Eslynn Deraniyagala, 'The Debate goes on ... From the casebook of a social worker...', *The Ceylon Observer*, 11 January, 1953, p. 8

Clearly Deraniyagala's view on family planning had strong undertones of eugenics, more than any argument supporting birth control and family planning.

In reply to an article written by Mrs Deraniyagla in *The Ceylon Observer*, a professor of paediatrics at the University of Ceylon captured the political connotation of the term family planning. In the same column of the following week's paper where the original article appeared, he defined family planning as 'a less offensive but more comprehensive name for contraception or birth control.'²³⁹ He went on to explain that family planning did not raise any moral objections as it did not carry any coercive connotation. As I have pointed out above, policy makers and practitioners have not paid enough attention to the fine line dividing the terms family planning, contraception and birth control, because they were keen to settle with a politically correct term. These newspaper articles and the FPA Annual Reports show that there was an attempt to define what family planning meant and what purpose it served in Sri Lanka at the inception of the Association.

From the time it was founded in 1953, the FPA discouraged abortion. In the Silver Jubilee Anniversary Souvenir of the FPA, Mrs Leila Basnayake, president of the FPA in 1977, shared her reminiscences on how Dr Siva Chinnatamby (the medical director of the FPA of Ceylon from 1959 to 1979) 'gently but firmly' refused a woman who wanted to undergo an abortion at the De

²³⁹ Professor of Paediatrics of the University of Ceylon, 'The Debate goes on ... A Doctor replies to The Catholic point of view ...', *The Ceylon Observer*, 18 January, 1953, p. 8, 9.

Soysa maternity hospital.²⁴⁰ One of the unique characteristics of the FPA is that its clinics provided and continue to provide fertility advice to women who have problems in conceiving. When Chinnatamby joined the FPA in 1959 she requested from Mrs Fernando, secretary of the FPA, to let her practice her speciality in fertility. Thereafter the FPA made fertility clinics part of its programme.²⁴¹ This was indeed a very unusual characteristic, which was never spoken about or dealt with by the Sinhala Buddhist extremists who attacked the work of the FPA and Chinnatamby's efforts on the grounds of disturbing the ethnic balance of the country. Family planning was criticised by extremists especially in the 1960s as a moral degradation and a malicious scheme by the minority ethnic race, the Tamils—Chinnatamby was also a Tamil—to disturb the ethnic proportion of the country, disregarding other, useful services offered by the FPA.²⁴²

In the 1960s, the services of the FPA were described by Abhayaratne and Jayawardena as 'some children where there were none, fewer children where there were too many.'²⁴³ Whether it is a development issue or a women's health issue, family planning had gained momentum in Sri Lanka by the mid-1950s. And, as I mentioned earlier, the concept of eugenics, birth control and family planning were all intertwined rather than distinct in the programme throughout the history

²⁴⁰ De Silva (ed.), *A History of Family Planning*, p. 13.

²⁴¹ Huston, *The Right to Choose*, p. 52.

²⁴² I discuss these ethnic connotations in Chapter Three with regard to the Pill trials in Sri Lanka.

²⁴³ De Silva (ed.), *A History of Family Planning*, p. 109.

of family planning in Sri Lanka. And the government policies and attitudes of the policy makers also played a role in blurring the boundaries between these concepts.

Family planning did not mean the same to everyone; as shown above, even the few upper class people who attended the inaugural meeting of the FPA did not have a consensus on what family planning was. Some perceived family planning as synonymous with population control, while others took it as an altruistic motive of improving the lives of the poor, destitute mothers. For some it was an effort at eugenics towards the development of the state, for others it was a personal intervention to achieve a greater good. Although both Dr Rutnam and Mrs Fernando were members, the topic of family planning was not welcome in the ACWC. Family planning meant diverse things to different people, according to their personal and organisational objectives.

The Relationship between the State and the Family Planning Association

Although, the FPA remained an NGO, it sought the approval of the government for its activities. But FPA Annual Reports, contemporary newspaper articles and my interviews with past presidents show that the government of Sri Lanka was not consistent in its support. The relationship remained cordial and supportive but, especially during general elections, the government took an indifferent stand. The opposition periodically criticised the party in power for supporting the

‘immoral’ cause of family planning, and the party in power regularly refrained from taking a stand on issues of family planning and population. Attesting to this, Abhayaratne and Jayawardena pointed out that the government supported the FPA in a number of ways to carry out its work, but it ‘persistently refused to make any statement of policy, positive or negative, on the subject.’²⁴⁴ When the FPA was granted funds by the government for the first time in 1954, it was on the condition that the FPA ‘had to promise to keep it secret, for they feared the political fall-out if it were made known,’ said Phyllis Dissanayake, one of the founding members.²⁴⁵

The initial grant by the government for the FPA in 1954 was LKR 2,500.²⁴⁶ The grant was first increased to LKR 10,000 per annum in 1956 and then to LKR 75,000 in 1957.²⁴⁷ Even though the government grant increased meteorically, the government did not take any policy decision on family planning. Interaction happened in other ways. The politicians in the 1950s had strong personal connections with the pioneers of the FPA, because they all belonged to the same social strata. Politicians and family planners did cooperate in their activities, but were careful not to make this cordial relationship visible to the public eye.

Despite the government’s hesitation to take up the cause of family planning in the early 1950s, the government signed an agreement with the Swedish government to conduct a pilot-study-cum-action Family Planning Programme in

²⁴⁴ Abhayaratne and Jayawardena, *Family Planning*, p 15.

²⁴⁵ Huston, *The Right to Choose*, p. 41.

²⁴⁶ *Fifteen Years of Family Planning in Ceylon 1953–1968*, Colombo, FPA, 1968, p. 40.

²⁴⁷ *Golden Jubilee Souvenir 1953–2003*, Colombo, FPA, 2003, p. 259.

1958.²⁴⁸ This was the first agreement of its kind between two governments on conducting a family planning project.²⁴⁹ According to this agreement, the Swedish government offered LKR 3,000,000 to start a pilot project in two or more rural areas.²⁵⁰ According to Hyrenius and Ahs' evaluation, the main purpose of this project was to

investigate attitudes towards family planning, the prospects for family planning activities, to give the population instruction in the methods of family planning and to assist in training Ceylonese public health staff in work of this kind.²⁵¹

The project was implemented in Bandaragama (a village twenty-five miles south of Colombo, predominantly a Sinhalese Buddhist agricultural community) and Diyagama (a tea estate in the hill country, predominantly a Tamil Hindu plantation community).²⁵² A Swedish physician and a nurse were sent by the Swedish International Development Cooperation Agency (SIDA) to 'conduct the Pilot Trial using chemical and mechanical methods to see if Ceylonese were "planning minded" and to ascertain the best method to be advocated for fertility regulation.'²⁵³ Why was Sweden interested in funding a family planning programme on a small island of the Indian Ocean when they did not have any

²⁴⁸ *Annual Report of the Family Planning Association of Ceylon 1969–70*, Colombo, FPA, 1970, p 3.

²⁴⁹ Report on *Evaluation of Swedish Assistance for Family Planning in Sri Lanka*, May 1984, SRI DCO Archive, Report No. 27, Box No. 2.1/4, p. 2.

²⁵⁰ De Silva (ed.), *A History of Family Planning*, p. 112–13.

²⁵¹ Hannes Hyrenius and Ulla Ahs, *The Sweden-Ceylon Family Planning Pilot Project; Analysis and Evaluation*, undertaken on behalf of the Swedish International Development Authority (SIDA), Goteborg, 1968, p. 6.

²⁵² *Ibid.*, p. 19.

²⁵³ Chinnatamby, 'Perspective in Safe Motherhood', p. 9.

colonial interest in Sri Lanka? Or to put it differently, what was so attractive about Sri Lanka for the Swedes to fund a family planning project in the 1950s? Answering these questions would be difficult without providing a brief description of the history and politics of the global population control programmes which date back to the early 1900s.

A Brief History of Global Population Control Programmes

Many historians writing from Marxist, feminist and postcolonial traditions perceive eugenics as the predecessor of population control, which ‘changed its name and to some extent its clothes’ after the Second World War.²⁵⁴ Eugenics was essentially about fertility regulation and the two aspects of fertility—quality and quantity—were termed ‘positive eugenics’ and ‘negative eugenics’ respectively in the early twentieth century.²⁵⁵ ‘Positive eugenics’ promoted procreation among desired population cohorts such as the middle class—educated and ‘healthy groups’—to create and produce the perfect human being for the modern world. ‘Positive eugenics’ was promoted in the early twentieth century in reply to two fears. The first was the fear of declining numbers in Europe (reduction of the best stock) and the second was of the increasing numbers of the colonised (proliferating of the bad stock). Bashford and Klausen remind us that there was a

²⁵⁴ Alison Bashford, ‘Internationalism, Cosmopolitanism and Eugenics,’ in Alison Bashford and Philippa Levine, (eds), *The Oxford Handbook of the History of Eugenics*, Oxford: Oxford University Press, 2010, p 164. Betsy Hartmann, Mohan Rao, Matthew Connelly and Ines Smyth to name a few.

²⁵⁵ Diane B. Paul and James Moore, ‘The Darwinian Context: Evolution and Inheritance’, in Alison Bashford and Philippa Levine, (eds), *The Oxford Handbook*, p. 31.

rapid decline in population growth rate from the 1880s in Europe which was widely perceived as ‘a key component of “degeneration”.’²⁵⁶ The corrective measure proposed by the West was negative eugenics. As Stoler puts it, the target of ‘negative eugenics’ was the ‘unfit’, ‘the poor’, ‘the colonized’ and ‘unpopular strangers’.²⁵⁷

According to negative eugenics, sterilisation was the solution to limit the growth of problem populations. This was a particularly popular method suggested to curb Asia’s burgeoning population. Commentators on Margaret Sanger’s Birth Control International Information Centre organised a conference on ‘Birth Control in Asia’ between the 23 and 25 November 1933 at the London School of Hygiene and Tropical Medicine. The aim of the conference was to discuss the ‘economic and political problems created by pressure of excessive populations in Eastern territories.’²⁵⁸ These conferences helped, as mentioned in Chapter One, to create the ideology of population control in Asia among policy makers and academics of Asia, which was termed by Hartmann ‘conventional wisdom’.²⁵⁹ Hartman also observed that according to this ideology ‘the only way out for the poor is to stop being born,’ which was justified by the rich and powerful ‘by a wave of a magic wand’ called population control programmes.²⁶⁰ Affirming this,

²⁵⁶ Susanne Klausen and Alison Bashford, ‘Fertility Control: Eugenics, Neo-Malthusianism and Feminism,’ in Alison Bashford and Philippa Levine (eds), *The Oxford Handbook*, p 98.

²⁵⁷ Stoler, ‘Making Empire Respectable’, p. 644.

²⁵⁸ Wellcome Library, London, Reference to the pamphlets/programmes on the Birth Control in Asia Conference PP/EPR/F. 1/ 2. One Dr de Silva from Sri Lanka (then Ceylon) had attended this conference.

²⁵⁹ Hartmann, *Reproductive Rights and Wrongs*, p. 3

²⁶⁰ *Ibid.*, p. 34.

Klausen reminds us that by the 1930s there were active birth control movements in at least thirty countries around the world.²⁶¹ Given the global context, population control in Asia became the responsibility of the West for its own economic and security reasons. In the light of such a historical background, why was Sri Lanka chosen over other countries by the Swedish government for funding the first ever government assisted family planning programme in the world?

Funding Population Control Programmes

The US and Sweden were the first countries to fund population and family planning programmes in the late 1950s.²⁶² 'Total funding for population and family planning by donor governments increased from \$13.6 million in 1965 (Donaldson, 1990) to \$980 million in 1994 (United Nations Population Fund, 1999).'²⁶³ As Hartmann points out, the United States' funding for population programmes (research and implementation strategies) in the Third World was more an economic and security measure than a charitable endeavour. Following a robust eugenics career, the Swedish government was one of the very first to support family planning programmes and movements in the early 1960s to train the first generation of family planning leaders in developing countries.²⁶⁴ As mentioned above, the Swedish government assisted Sri Lanka in organising a population

²⁶¹ Susanne M. Klausen, *Race, Maternity, and the Politics of Birth Control in South Africa, 1910–1939*, Palgrave, Macmillan, 2004, p. 9.

²⁶² Judith R. Seltzer, *The Origins and Evolution of Family Planning Programs in Developing Countries*, New York, Rockefeller Foundation, 2002, p. 11.

²⁶³ Ibid., p. 37.

²⁶⁴ Robinson and Ross (eds), *The Global Family Planning Revolution*, p. 3.

project in community family planning from 1958 to 1983.²⁶⁵ 'Swedish aid to Sri Lanka during this 25-year period was SEK 33m of which since 1972, 18 per cent' was used 'for building and construction, 41 per cent for supplies of contraceptives and 35 per cent for equipment.'²⁶⁶ These initiatives were results of the writings of economic demographers Ansley Coale and Edgar Hoover, and economists Stephen Enke and Gunnar Myrdal.²⁶⁷ However, according to the evaluation report of 1984, the experience gained from the first family planning programme conducted in Ceylon in 1958 became useful in the design of other countries' national programmes in the future.²⁶⁸ In other words, Sri Lanka was used as a testing laboratory for family planning programmes by the developed countries.²⁶⁹ As I have mentioned before, Sri Lanka was chosen as a social laboratory to conduct research on health, social medicine, population growth and cultural and economic change in the 1950s. As one social scientist wrote,

Ceylon's unique importance as a social research locale rests in the manifestation of problems and processes which are not only Ceylonese but Southeast Asian. There is much to support the view that Ceylon approximates a microcosm of Southeast Asia which is both stable and of workable size.²⁷⁰

²⁶⁵ Report on *Evaluation of Swedish Assistance for Family Planning*, p. 1. See also *Population and Family Planning Activities in Sri Lanka*, Colombo, Population Division, Ministry of Plan Implementation, 1979, p. 11.

²⁶⁶ Ibid., p. 1.

²⁶⁷ Robinson and Ross (eds), *The Global Family Planning Revolution*, p. 3.

Gunnar Myrdal headed the group of experts who advised the National Planning Council of Ceylon in 1959.

²⁶⁸ Report on *Evaluation of Swedish Assistance*, p. 2.

²⁶⁹ I will further interrogate on the 'laboratory status' of Sri Lanka in the third chapter where I discuss the clinical trials conducted for the introduction of the Pill to Sri Lanka.

²⁷⁰ Rockefeller Collection, Record Group 1.1/462, Box 1, Folder 2, letter from Ryan to Watson on the 16 April 1950. Dr. Robert B. Watson was the Director, Far Eastern Region, International Health Division of the Rockefeller Foundation and Professor Bryce Ryan was the Chairman of the

With the signing of the agreement for the pilot project on family planning with Sweden, Sri Lanka officially became a laboratory to design family planning programmes for South Asia. Sri Lanka's laboratory status was strengthened in 1961 with the undertaking of clinical trials for the introduction of the birth control pill to South Asia, which I will address in the next chapter.

Family Planning as Part of Planning Ideology in the Late 1950s and 1960s

In 1962, Prime Minister Mrs Sirima Bandaranaike proposed to incorporate family planning into the maternal and child health programme of the Ministry of Health.²⁷¹ Prior to her entry into national politics (upon the death of her prime minister husband in 1959), she worked as a volunteer at the FPA with other elite women. This was the first time that the leader of the state acknowledged the efforts of the FPA. Nevertheless, the then minister of education vehemently disapproved of family planning. He wrote in a Sinhalese daily, 'I am fully against family planning, and I consider it murder.'²⁷² Being a great supporter of nationalism propagated by Mr. Bandaranaike in the late 1950s, he used the term 'murder' in two senses. First, he used the word murder in the sense of disallowing children to be born. Second, he meant the murder of the nation (the Sinhala

Sociology Department at University of Ceylon (Now University of Peradeniya) from 1948 to 1952 and consultant to the Rockefeller Foundation from 1950-52.

²⁷¹ *Annual Report of the Family Planning Association of Ceylon 1969-70*, Colombo, FPA, 1970, pp. 4 & 19.

²⁷² Quoted in Nicholas Wright, 'Recent fertility change in Ceylon and prospects for the National family planning program,' in *Demography*, Vol. 5 No. 2, 1968.

Buddhist nation) as a consequence of family planning. His nationalist ideas did not allow him to perceive family planning as a mechanism for women to take charge of their bodies and reproduction, because women's bodies were bestowed with the responsibility of nation building in independent Sri Lanka.

Despite the opposition of some government ministers, in October 1965, the government made family planning part of its programme and overtook 150 family planning clinics previously run by the FPA. Moreover, the Family Planning Bureau was established under the direct administration of the assistant director of Maternal and Child Health.²⁷³

By placing family planning under the purview of Maternal and Child Health, the government recast family planning as a preventive health service for mothers. This in turn helped to provide an ideological legitimacy and respectability to the taboo topic of family planning. I see this as a moment of aligning women's reproductive behaviour with the development priorities of the state. I have discussed how the official rhetoric made women's health equal to reproductive health in Chapter One. Thus women were positioned at the centre stage of state development discourse as primary sites of change. As mentioned in Chapter One, the government's move to take on the question of family planning could be seen as the example of the zeitgeist of national planning ideology.

On the very first page of the 1963–64 Annual Report of the FPA, family planning is defined as '*pavul sanvidanaya sanvidanathmaka demavpiyabavayay*',

²⁷³ *Annual Report of the Family Planning Association 1969–70*, p 4. See also de Silva (ed.), *A History of Family Planning*, p. 44.

which means ‘planned parenthood is family planning.’²⁷⁴ Even though Planned Parenthood is an international organisation with the motto ‘every child is a wanted child’, FPA used the concept of planned parenthood to emphasise the planning ideology of the 1960s. By the end of the decade, the aim of the FPA was ‘to make family planning a way of life for all our people and not only for the more affluent.’²⁷⁵

With family planning becoming a part of the state building project, the FPA’s role narrowed down to ‘helping to train doctors and paramedical staff, and to educating the public particularly in rural and estate areas about as to the meaning of Family Planning.’²⁷⁶ Thus, the FPA became the educational and propaganda arm of the state family planning programme and acted as a catalyst of changing attitudes of the public. The role of the FPA changed from conceptualising family planning to creating a ‘common sense’ on family planning. On 5 May 1965, the minister of finance, Mr U.B. Wanninayake, declared the FPA an approved charity under section 67 (1) of the Inland Revenue Act No. 4 of 1963.²⁷⁷

The agreement with the Swedish government ended in 1963, and in 1965 a new agreement was signed. By 1968, through the project, ‘610 medical officers and 2,460 para-medical personnel (nurses, midwives, public health inspectors, health

²⁷⁴ *Annual Report of the Family Planning Association on Ceylon 1963–64*, Colombo, FPA, 1964, p.1

²⁷⁵ *Annual Report of the Family Planning Association 1969–70*, p 15

²⁷⁶ *Ibid.*, p 19.

²⁷⁷ De Silva (ed.), *A History of Family Planning*, p. 121.

educators etc.) had been trained in family planning work.²⁷⁸ Suggestions and training provided by the Swedish government on conducting a national family planning programme led to a discussion on incorporating sex education to the school curriculum. After much debate and contemplation, this proposal was rejected. However, population education was introduced in 1972 as part of the six million dollar multi-disciplinary UNFPA project by incorporating population education into five subject areas namely, 'science, social studies, mathematics, health education and the first languages'.²⁷⁹

Implementing Family Planning as Population Control Programmes in the 1970s

As mentioned in Chapter One, in 1972–73, the government declared a national policy on family planning in its Five Year Plan (1972–76).²⁸⁰ This was also part of the UNFPA funded multi-disciplinary population programme.²⁸¹ Since the government took direct responsibility for family planning services and expansion, it appeared necessary to rethink the role of the FPA in the early 1970s. The FPA was careful enough to refrain from duplicating family planning activities and services offered by the government.

²⁷⁸ Ibid., p. S 4.13

²⁷⁹ *New Dimensions in Population Planning and Development: International Congress, Silver Jubilee Celebrations*, Colombo, FPA, 1978, pp. 103-104.

²⁸⁰ *Population and Family Planning Activities in Sri Lanka*, Population Division, Ministry of Plan Implementation, Colombo, 1979, p. 26.

²⁸¹ According to the Governing Council General Report of the UN Development Programme, the first country programme was approved in 1973 in the amount of \$3.4 million for four years. The second country programme of \$5.3 million was approved for the period of three years, between 1982 and 1985. The third country programme was approved in 1987 in the amount of \$5 million for five years starting in 1987.

Even though the government undertook family planning on a major scale, it left important issues such as sterilisation outside its scope. In order to address this gap, the 'FPA shifted its emphasis from family spacing to family limitation, from condom, pill, IUD and injection to tubectomy and vasectomy by 1973.'²⁸² Thus, population control measures were introduced through the FPA in the 1970s, while the government adhered to a family planning programme. This was quite different to the Indian approach to sterilisation. The Indian government introduced sterilisation in 1959 as part of its programme and conducted abusive sterilisation camps during 1975–77.²⁸³ However, the government of Sri Lanka carefully left this politically costly and conflicted area to the FPA, an NGO.

Why did the FPA change its focus from family planning to population control in the early 1970s? Hartmann noted that one of the four main areas of the US Agency for International Development (USAID) was population control during this time.²⁸⁴ According to Brian Atwood, administrator of the USAID, this was a period of waging war on population growth with multiple weapons such as unmet need of contraceptives, maternal health, prenatal care, safe sex, social education and women's empowerment.²⁸⁵ As one of the main funders, USAID enjoyed the privilege in pressuring the UNFPA to conduct all-encompassing population programmes.²⁸⁶ Thus, as part of the UNFPA multidisciplinary population

²⁸² De Silva (ed.), *A History of Family Planning*, p. 155.

²⁸³ Rachel Simon-Kumar, 'Marketing' *Reproduction? Ideology and Population Policy in India*, New Delhi: Zubaan, 2006, p. 102.

²⁸⁴ Hartmann, *Reproductive Rights and Wrongs*, p. 114.

²⁸⁵ Ibid., p. 115.

²⁸⁶ Ibid., p. 116.

programme, the FPA became associated with the Ministries of Labour, Information and Broadcasting, Health, Education, Local Government and Home Affairs, and played a vital role in managing the eleven projects to control the population growth rate of the country.²⁸⁷

By the early 1970s, the unmet need of contraceptives—one of the weapons mentioned by Atwood—was addressed through the programme on social marketing of contraceptives. In 1974, the Pill became an over-the-counter drug in Sri Lanka. In 1974, Ayurvedic physicians were trained in family planning methods in order to take the Pill to rural areas. A youth volunteer programme was setup in 1975 to educate rural populations on family planning.²⁸⁸ The decade of the 1970s had a special significance in shaping the future of the young population of Sri Lanka due to two reasons. First, the youth uprising in 1971 drew attention to high rates of unemployment. Second, the opening of the Sri Lankan economy to Western entrepreneurs in 1977 created job opportunities in factories of the Free Trade Zone in Katunayake. The Sri Lankan youth at this time was largely unemployed. They were educated in village schools where they had imbibed strong Sinhalese Buddhist chauvinistic ideas. They were commonly known as *panas haye daruwo* (children of '56), the product of Prime Minister Mr. Bandaranaike's (1956–59) language policy generally known as the Sinhala Only

²⁸⁷ *Annual Report of the Family Planning Association of Sri Lanka 1975*, Colombo, FPA, p. 5.

²⁸⁸ The Pill became freely available and adapted to local conditions as *Mithuri* through the programme of social marketing of contraceptives launched in 1974. I have discussed this programme in greater detail in the next chapter.

Act of 1956.²⁸⁹ Due to this policy, they failed to develop the necessary English language skills to compete in the job market with their contemporaries educated in city schools. The frustration of unemployment and under-employment led to the first youth uprising of independent Sri Lanka in 1971.²⁹⁰

The Role of Youth in Population Education

Sri Lanka's UNFPA/UNDP driven population programme was launched in the year 1972–73. Almost all ministries became involved in the programme and made sure that information on family planning and contraception spread to the youth of Sri Lanka—until then strictly limited to married couples. The FPA formed a Youth Committee in 1975 to take the message of family planning and planned parenthood to rural areas because of the high proportion of youth—by 1975, 73 percent of the population were under 35 years—and to conform to the IPPF's emphasis on involving the youth in population activities.²⁹¹ Activities of the Youth Committee were further facilitated through the setting up of a volunteer system in

²⁸⁹ In 1956, keeping to his election promise, Bandaranaike replaced English with Sinhalese as the official language of Sri Lanka. This is commonly known as the Sinhalese Only Act of 1956. Scholars identify this as the beginning of the discriminatory treatment meted out to minority Tamils in Sri Lanka which paved the way for a 26-year ethnic war.

²⁹⁰ See Victor Ivan, *71 Kerella: JVP arambhaya ha vikashanaya (1964–71)*, Maharagama, Ravaya Publishers, 4th edition, 2010; R. Gunaratne, *Sri Lanka, a Lost Revolution? The Inside Story of the JVP*, Kandy, 1990; G. Samaranayake, 'The Changing Attitude Toward the Tamil Problem within the Janatha Vimukthi Peramuna,' in Charles Abeysekera and Newton Gunasinghe (eds), *Facets of Ethnicity in Sri Lanka*, Colombo, 1987; J. Uyangoda, 'Social Conflict, Radical Resistance and Projects of State Power in Southern Sri Lanka: the Case of the JVP,' in Markus Mayer, Darini Rajasingham-Senanayake and Yuvi Thangarajah (eds), *Building Local Capacities for Peace; Rethinking Conflict and Development in Sri Lanka*, New Delhi, 2003; S.T. Hettige, *Wealth, Power and Prestige: Emerging Patterns of Social Inequality in a Peasant Context*, Colombo, Ministry of Higher Education, 1984; and A.C. Alles, *The JVP 1969–1989*, Colombo, Lake House Investments Ltd, 1990 for an insightful analysis of the 1971 JVP uprising. The second JVP uprising took place in 1989 which I have discussed in detail in Chapter Four.

²⁹¹ *Annual Report of the Family Planning Association 1975*, p. 6.

1976. When I inquired about youth involvement in family planning from the first executive director of the FPA (1975–2005), he said that ‘the volunteer system paved the way to take sexual and reproductive knowledge to the grassroots.’²⁹² He was quite proud of this achievement since it was set up during his tenure and is still running. He added triumphantly that the ‘volunteer system was the most successful programme ever introduced by the FPA.’²⁹³

It became evident through the discussions that I had with retired FPA officials that the youth volunteer programme was a pragmatic move to get youth involved in discussions on family planning and population problems in rural areas after the first youth uprising (*Janatha Vimukthi Peramuna* – JVP Peoples’ Liberation Movement) in 1971. The purpose was to give this group of educated people—with vernacular skills and an imbibed Sinhalese Buddhist ideology—the opportunity to perform to their abilities and contribute to development planning by addressing a ‘dire social problem’ faced by the country. Even though the youth volunteer programme appeared to be very successful and pragmatic at first glance, I found it difficult to comprehend how it was possible for young people to promote family planning among villagers in a society where sex was a topic exclusively discussed by the married. When I inquired after this from the former executive director of the FPA, he said

Since they were considered the ‘children of 56’, they were well respected in the rural areas. So it wasn’t an issue in the mid-1970s for

²⁹² Interview with the first executive director of the FPA (1975–2005) on 21 December 2009 at his residence in Rajagiriya.

²⁹³ Ibid.

them to talk about family planning, and at the same time they made it very scientific, so people didn't feel that they were discussing a taboo topic.²⁹⁴

By 'respect' he meant a certain hegemonic status that the 'children of 56' enjoyed in rural areas. In fact during a brainstorming session of a youth workshop conducted by the FPA in 1974, the young participants proposed to call the FPA of Sri Lanka an 'Organisation for the Protection of Society' and to work towards erasing the misconceptions on family planning at the village level.²⁹⁵ The Youth Committee of the FPA organised seminars on population education in the project areas all over the country—Jaffna, Weligama, Harispattu and Badulla. Additionally, three seminars were held at university campuses and in three leading schools on request.²⁹⁶ In retrospect, scholars see this youth involvement in the population problem as an activity geared at 'preparing a generation of family planning leaders in developing countries,' which allowed the West to perpetuate the status quo, i.e. to retain its superior position, through controlling the 'problem populations' of the East.²⁹⁷ As Hartmann explained, involvement of youth in family planning activities helped create a 'cult of population control' among policy makers and the implementers of family planning programmes in Sri Lanka by the late 1970s.²⁹⁸ Apart from the youth, on the suggestion of the IPPF, the FPA trained

²⁹⁴ Ibid.

²⁹⁵ *Annual Report of the Family Planning Association 1975*, p. 35.

²⁹⁶ Ibid., p. 36.

²⁹⁷ Robinson and Ross (eds), *The Global Family Planning Revolution*, p. 3.

²⁹⁸ Hartmann, *Reproductive Rights and Wrongs*, p. 104.

another group on family planning activities to reach the villagers—the Ayurvedic physicians.

Ayurvedic physicians were one of the five forces that Mr. Bandaranaike wanted to groom to be leaders in rural areas as he stated in 1956 during his election campaign.²⁹⁹ In 1974, they were approached by the IPPF through the FPA to take the family planning message and the Pill to the rural areas. I identify them as the most appropriate group that possesses the traditional and cultural hegemony necessary to address and influence rural communities to carry out the planning ideology of the state.

Seeking the Support of Ayurvedic Physicians

Hartmann scorned the alienation of traditional local healers and midwives instead of winning them over and involving them in the modern family planning programmes in Egypt, but the situation in Sri Lanka was quite the contrary.³⁰⁰

At the first international scientific congress of the FPA of Sri Lanka in 1974, Dr Malcom Potts, director general of the IPPF, stressed the importance of winning the support of the traditional Ayurvedic physicians for the modern family planning programme in order to convey the knowledge and message to the rural areas. Addressing Ayurvedic physicians he said,

²⁹⁹ The five forces, as he called them, were *Sangha* (Buddhist priests), *Veda* (Ayurvedic physicians), *Guru* (teachers), *Govi* (farmers), *Kamkaru* (labourers). His election promise to make Sinhala the official language of the state attracted these five forces by the promise of a privileged position in the villages.

³⁰⁰ Hartmann, *Reproductive Rights and Wrongs*, p. 64.

You have a skill with people that the Western doctor often lacks. The Prime Minister, the IPPF Secretary General, and many of us have welcomed the participation of ayurvedic doctors. We at this conference say “Please help us. Please take the Pill we have invented and tell us how to distribute it.” In other words we have done the easy part, now please help us with the difficult bit. Perhaps we should say that we are very sorry we have been so taken up with our microscopes and statistics that we failed to consult you earlier.³⁰¹

According to the 1901 census, there were 3,424 *vedaralas* (traditional medical practitioners, later called Ayurvedic physicians) in the country. Ayurveda, Siddha and Yunani were the traditional medical practices in Sri Lanka prior to the introduction of Western medicine, during the colonial period. In the 1970s, there were 10,163 registered traditional medical practitioners in Sri Lanka.³⁰² According to Pott’s suggestion, a three day training programme on family planning for Ayurvedic physicians was carried out by the Family Health Bureau (FHB) and the Department of Ayurveda in November 1975. At this workshop, 165 Ayurvedic physicians from all over the country were trained. The FHB received funds from the IPPF through the FPA to conduct this training programme, and, by 1977, over eight hundred traditional Ayurvedic physicians were trained.³⁰³ These programmes were carried out in ‘Colombo, Kurunegala, Galle, Kandy, Jaffna and Ratnapura.’³⁰⁴ By the 1980s, the Ayurvedic physicians were advocating family planning methods to the rural peasants in order to service the development project of post independence Sri Lanka.

³⁰¹ De Silva (ed.), *A History of Family Planning*, p. 33.

³⁰² Kamalika Pieris, *The Medical Profession in Sri Lanka 1843–1980*, Borelesgamuwa, Visidunu Publications, 2001, p. 78.

³⁰³ De Silva (ed.), *A History of Family Planning*, p. 154.

³⁰⁴ *Annual Report of the Family Planning Association 1976*, Colombo, FPA, 1977, p. 18.

The involvement and commitment of both these groups—youth and Ayurvedic physicians—were significant to the cause of family planning both locally and internationally. Borrowing an anthropological term, Sarath Amunugama termed Ayurvedic physicians ‘cultural brokers’ for various services they provided as ideological and cultural leaders of the community.³⁰⁵ Strategies put forward by the global population programme (getting the support of the traditional leaders of society) blended very well with the contemporary local scenario. Thus controlling the population growth rate became number one priority in the family planning programme, and at the same time the ‘cult of population control’ got deeply and soundly rooted in Sri Lanka.

With these initiatives the idea of family planning reached the masses, by the end of the 1970s. But the FPA *Annual Report of 1969–70* reported a problem with the way in which the meaning of family planning was perceived by the people. It states that family planning has become synonymous with contraception for village folk and made them suspicious of the Association.³⁰⁶ According to my reading, the absence of a Sinhalese term for contraception is the subtext of this statement. Contraception is either translated as *upath palana krama* (birth control methods), or as *pilisindagæneema walakvana vidyanukoola krama* (ways of scientific regulating methods to stop conception). The terms ‘control’ (*palanaya*) and ‘stop’ (*walakvana*) used in Sinhalese do not articulate the liberating,

³⁰⁵ Sarath Amunugama, ‘Sociological Factors in Family Planning Publicity Programmes,’ in *Report of a Seminar on Population Problems, held for representatives of the mass media*, Bangkok, UNESCO Regional Office for Education in Asia, 1974, p. 23. (pp. 18–29).

³⁰⁶ *Annual Report of the Family Planning Association 1969–70*, p. 12.

empowering aspect of contraception, instead emphasises an authority over women's bodies. In other words, the shift from (*palanaya*) control to (*salasum kireema*) planning which was clearly articulated within the global population discourse was not captured through the Sinhalese translation. So it was inevitable that family planning became an equivalent to contraception in Sri Lanka. My oral history interviews also supported this archival evidence.

During my interviews with retired school teachers, I had noticed that they used both terms—birth control (*upath palanaya*) and family planning (*pavul saelasumkireema*)—in Sinhalese interchangeably. I asked them whether they see or feel any difference between these two terms. For some, the implications of both terms were the same. A Sinhalese language teacher explained to me in detail that though birth control and family planning do mean different things, this difference is not marked within day to day usage. Ultimately, the meanings of both these terms converge to control population growth.³⁰⁷ As a consequence of these initiatives and the energetic promotional campaign carried out by the Ministry of Plan Implementation planning ideology was firmly established by the late 1970s.

³⁰⁷ Interviews with Mrs Vida, on 14 June 2010, at an orphanage in Wellawatta where she volunteers; Mrs Jaya, at her residence in Kohuwala, on 5 July 2010; Mrs Perera, on 14 July 2010, at her residence in Piliyandala; and Mrs Dhana, on 24 July 2010, at her residence in Maharagama.

The Family Planning Programme during the Dynamic Implementation Mode of the Late 1970s

As mentioned in Chapter One, in 1977, although there appeared a change in government with the election of President J.R. Jayawardena of the UNP, the UN funded population programme was continued with much vigour. In 1977, a Population Division was set up in the Ministry of Plan Implementation. The election manifesto of the UNP clearly emphasised the commitment to a vigorous population policy and family planning programme.

Enhanced family planning services will be provided by the State and financial incentives with a view to controlling the population explosion will be given to individuals who practice them. ... In the field of FP, emphasis of the Government will be in the field of service oriented programmes to enable motivated couples and individuals to receive family planning services and to undergo vasectomy or sterilization voluntarily.³⁰⁸

Government tax policies were also reoriented in favour of small families. This was illustrated by the budget speech of the minister of finance in 1978:

The allowance of Rs. 12,000 will be a fixed amount and will not vary with the number of children. I trust this will be an appropriate disincentive to large families. It is my intention to introduce further tax disincentives to large families in due course. Population growth must be curbed if we are to achieve our objectives of eliminating unemployment, shortage of food and housing, and the depletion of our natural resources. Tax policy will be geared to this end.³⁰⁹

Under the 1977 government, the family planning programme was revamped in line with the development plans of the state, emphasising the Mahaweli

³⁰⁸ *Population and Family Planning Activities in Sri Lanka*, p. 12.

³⁰⁹ *Ibid.*

Development Programme, the Free Trade Zone, and labour migration of semi-skilled workers to the Middle East.³¹⁰ Monetary incentives were introduced for voluntary sterilisation in the mid-1970s.³¹¹ It was India that took the initiative of introducing the first large scale incentive scheme of cash payments on a vasectomy programme in the late 1960s.³¹² Following the Indian example, by 1979 Sri Lanka extended its incentive scheme to the motivator and the provider, which meant cash payments to the surgical team as well.³¹³ 'Under this scheme LKR 65 is paid for a female sterilisation and LKR 35 for a male sterilization.'³¹⁴ Further the incentive scheme was augmented by providing leave to all acceptors of voluntary sterilisation. Men were given three and women were given seven full days of paid leave. Initially the cash incentive was LKR 100 for acceptors of voluntary sterilisation, from October 1980 this payment increased to LKR 500 and then reduced to LKR 200 in February 1981. By the end of 1981, again it increased to LKR 300 and finally in June 1983 this was settled at LKR 500 per head.³¹⁵

Even though the former medical director of the FPA claimed that Sri Lanka was not pronounced to have been conducting an abusive sterilisation programme

³¹⁰ Find a detailed discussion on the economic changes of 1977 in relation to women's bodies in Chapter one.

³¹¹ Symonds and Carder point out that there was a debate in the late 1960s within the UN on promoting effective family planning measures. Encouraging late marriages and incentives for smaller families were two such decisions that came out of the debate. See Richard Symonds and Michael Carder (1973).

³¹² De Silva, Thapa et al., 'Compensatory Payments and Vasectomy Acceptance,' p. 143.

³¹³ Ibid., p. 144.

³¹⁴ *Voluntary Sterilization Programme in Sri Lanka*, Colombo, Population Division, Ministry of Plan Implementation, 1983, p. 13.

³¹⁵ Ibid., p. 13–14. See also de Silva, Thapa et al., 'Compensatory Payments and Vasectomy Acceptance,' p. 144–45; and W. Indralal de Silva, 'Do Fertility Intentions and Behaviour Influence Sterilization in Sri Lanka?' *Asia Pacific Population Journal*, 7:4 (1992), p. 57.

in the 1980s, my interview with the retired secretary of the ministry of Plan Implementation painted quite another picture. When he was explaining the energetic population control programme that he was leading in the 1980s, he said that

Even though abortion is still illegal in Sri Lanka I supported the abortion clinics and in fact I used to provide those doctors with menstrual regulatory kits, because my population policy was to somehow stop children being born for the sake of developing the country.³¹⁶

That is to say, to do everything in his power to meet the target of stopping children from being born, he amended the incentive scheme accordingly by monitoring the sterilisation programme very closely. Also he told me about instances where he released from custody the staff of abortion clinics that were raided by the police.

The compensatory payment for sterilisation is still being paid at the same rate that was paid in 1983—LKR 500 for volunteers and LKR 65 for medical staff.³¹⁷ Even though Sri Lanka has adopted the conceptual shift from family planning to reproductive health and rights in 1996 as advocated by the ICPD in 1994, remnants of old notions such as sterilisation incentives still remain part of the women's health programme.³¹⁸ These remnants prove the point made by the

³¹⁶ Interview with the retired secretary to the Ministry of Plan Implementation, on 7 August 2011 at his office in Colombo.

³¹⁷ General Circular No. 01-09/2007, 'Payment for female/male Sterilisation', issued on 3 April 2007 by the FHB, Colombo.

³¹⁸ I will discuss the 'controlled and planned' mind set of the policy makers of Sri Lanka in Chapter Five.

professor of demography, mentioned at the beginning of this chapter, about the Sri Lankan policy makers' lack of understanding on global conceptual shifts.

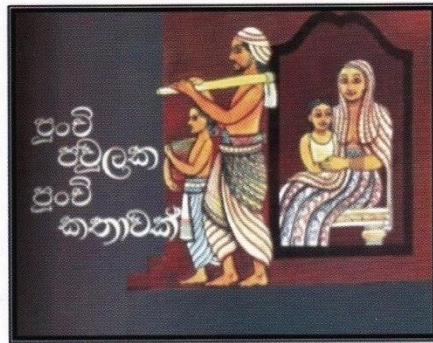
In the global women's health literature, the family planning programme of Sri Lanka is considered a fair and just programme when compared to the Indian situation.³¹⁹ However, an attentive reader cannot miss the hints of an implicit population control in the measures as slogans, logos and maternity leave provision from the era of development plan implementation. *Punchi pavula raththaran* ('a small family is golden') was one of the slogans that all my interviewees remembered, but surprisingly nobody knew who came up with it originally.³²⁰ Even though I could not find the original author of the slogan, the retired secretary of the Ministry of Plan Implementation showed me the picture he designed to accompany this slogan during his tenure. In his contribution to the book *ICPD – 15 Years On*, he mentioned that he got the painting (see below) from a 'famous image of our ancient temples.'³²¹ However, in the interview, he explained to me that the painting was created imitating the style of old temple drawings. Thus, he used this style to spread the idea that a family with two children has been the norm since ancient times.

³¹⁹ Health professionals that I interviewed took the sterilisation camps in India as counter example to defend the Sri Lankan programme.

³²⁰ All the retired teachers, members of the FPA, officials at the FHB and midwives remembered the slogan: 'small family is golden' (*Punchi Pavula Raththaran*) which was publicised with full force in the 1980s.

³²¹ Weerasooria, 'Pre ICPD Activities on Population and Development,' p. 4.

Temple painting used for family planning motivation



When I expressed my surprise he said quite defiantly,

Who is going to question me on this now? Even if I'm questioned, I will say that the painting is found in a temple in Dambulla, and who is going to cross check that? I used to do these type[s] of *gimmicks* (his emphasis) in order to get things moving, you know?³²²

Taking all his 'gimmicks' into consideration I wonder whether we could still call these implementation methods fair, democratic and just? Was not there a hint of an implicit forcefulness in these programmes? As Hartmann suggests (in a very sympathetic note), family planning programmes in the Third World became forceful and undemocratic not through the

fault of individual health and family planning workers—they are themselves caught in a system where sensitivity in meeting women's needs goes unrecorded, and merit is judged by how well they achieve population control targets.³²³

³²² Interview with the retired secretary of the Ministry of Plan Implementation, 7 August 2011 at his office in Colombo.

³²³ Hartmann, *Reproductive Rights and Wrongs*, p. 38.

This is indeed very true about the way in which the Sri Lankan family planning programme was implemented especially in the 1980s.

During my interview with the retired deputy minister of health (1970–76), she expressed her disappointment with the extension of the incentive scheme to medical staff.

I told Wickrema not to do that, because it takes away people's dedication towards public work. But the times were changing then; it was the market economy that led everything, so the population programme could not escape the market forces, that was how sterilisation incentives were introduced.³²⁴

She also told me that she worked hard with other doctors on family planning issues, sometimes foregoing meal breaks. She was saddened by the placing of monetary value on the dedication of public servants. At the same time she was conscious of the forceful market that Sri Lanka opened itself to in 1977; this process I will discuss in detail in Chapter Four. The retired secretary of Plan Implementation's 'bold acts' best describe, to use Hartmann's phrase, the 'cult of population control' that Sri Lanka in the 1980s believed in. To put it in a different way, family planning was about development, economic progress and modernity (and about women's health to a small extent) during the 1980s. However, in Sri Lanka, it never became an issue of women's rights over their reproductive bodies; I will further elaborate on this in the final chapter of my thesis.

³²⁴ Interview with retired deputy minister of health (1970–76), 3 November 2010 at her residence in Colombo.

Concluding Thoughts

In the Silvery Jubilee Souvenir of the FPA in 1978, the founding secretary of the FPA stated that the Family Planning programme started in Sri Lanka as a welfare endeavour. Poor destitute women received help 'through contraception for overburdened incomes overcrowded homes, malnourished children and physically exhausted mothers.'³²⁵ By emphasizing 'abundance' it is clear that the objective of the FPA was to limit or control the numbers, In demographic language, to control the population growth rate. Even though these concepts: eugenics, birth control, population control, family planning and reproductive health, changed over the years in the family planning programme of Sri Lanka along with the global population and development trends, they are inextricably linked to one another. Through sources such as archival material from the FPA and FHB, newspapers, interviews with stalwarts of the family planning programme of Sri Lanka and retired school teachers, I argue that this conceptual shift was not addressed effectively during the policy making and implementation process in Sri Lanka.

The main reason for this existing tension between terms, concepts and the policy making process is that the policy makers of Sri Lanka are still neo-Malthusians in their thinking. They still ardently believe in the connection between population growth, food production and labour force that Malthus advocated in the eighteenth century. Thus the family planning programme of Sri Lanka soon embraced, to use again Hartmann's phrase, the 'powerful cult of

³²⁵ De Silva (ed.), *A History of Family Planning*, p. 7.

population control' by making the Pill an over-the-counter drug, introducing sterilisation incentives, training Ayurvedic physicians on family planning methods, establishing youth volunteer groups to educate villagers and introducing population studies to the school curriculum.

The 'laboratory' status of Sri Lanka was further entertained by local medical professionals by voluntarily undertaking clinical trials of the Pill in 1961 that led to a further silencing of women's bodies. The next chapter deals with the trajectory of the Pill in Sri Lanka, its rebranding as *Mithuri* (female friend), and its availability as an over-the-counter drug from 1974 to service the modern development project of independent Sri Lanka by subjugating women's bodies to the dominant development ideology.

Chapter Three

From Pincus' Pill to Chinnatamby's *Vanda Beheth* and Women's Female Friend *Mithuri* (1950–80)

Abstract

This chapter charts the history of the Pill in Sri Lanka to illustrate how the broader global discourse of population control has played out in the Sri Lankan national context. It explores the fraught story of Sri Lanka as a site for Pill trials in the 1960s, and provides a narrative of popular reactions to the widespread availability of the Pill by the mid-1970s. In particular, the chapter explores how universal population control as a development discourse of the state came under strain when confronted by the challenges of maternalist policies in an ethnically divided nation.

Through a cross reading of Sri Lankan research reports and the correspondence between Sri Lankan and International family planning pioneers, I show how Sri Lanka became a laboratory for global Pill trials. This prompted a discussion on contraception that revolved around morality, women's bodies and ethnicity resulting in the Pill being labelled *vanda beheth/pethi* (sterility pills) in the late 1960s.

Further, through my analysis of International Planned Parenthood Federation (IPPF) reports on the programme of social marketing of contraceptives in 1974 (*Mithuri*), contemporary Sinhalese and English newspaper articles, advertisements and interviews with one of the first Ayurvedic physicians trained in family planning methods in 1974, one of Chinnatamby's students and the successor of Chinnatamby at the FPA I will show how women's health and bodies became the ground in which market forces (*Mithuri*) replaced ethnic forces (*vanda beheth/pethi*).

Introduction

The journey of the Pill from the Worcester Foundation in Massachusetts to the De Soysa Maternity Hospital in Colombo was of historical significance to women's health in Sri Lanka, for two reasons. First, Sri Lanka became the first country in South Asia to voluntarily undertake clinical trials of the Pill in 1961 thus establishing its position as a social laboratory. Second, the clinical trials of the Pill established a link between the FPA and the government paving the way for the government to officially adopt family planning in 1965. Medical practitioners in Sri Lanka saw the Pill trials as a great contribution towards global medical research while family planners considered the Pill as a panacea for development.³²⁶ Sri Lanka was in the 'planning mode' in the late 1950s and the birth control pill came into being at a crucial time; it helped to plan the unplanned families of Sri Lanka.

The first part of this chapter examines the role played by Sri Lanka with regards to international efforts employed in developing and delivering the Pill to South Asia. I will provide a brief history of the initiator, Dr Siva Chinnatamby, and the trial venue, the De Soysa Maternity Hospital for Women in Colombo, in order to understand the broader context of the Sri Lankan Pill trials. Within this historical account, I will highlight the strong planning ideology that prevailed in Sri Lanka in the late 1950s that created a link between the FPA and the

³²⁶ Interview with the former Dean, Faculty of Medicine, University of Colombo (one of the first students of Dr Siva Chinnatamby at the Faculty of Medicine, University of Colombo in 1970) at his office in University of Colombo, on 9 June 2010. He spoke about Dr Chinnatamby and her family planning activities with great admiration.

government, culminating in the clinical trials of the Pill, in 1961. This in turn spurred the public health sector to take family planning on board, in 1965.

The second part of this chapter focuses on how Sinhalese Buddhist nationalists described the Pill as *vanda pethi* (sterility pills) in the 1960s and saw it as an attempt to disturb the ethnic balance of the country, and on the workings of the market forces in the Pill's rebranding in the 1970s. A decade and a half later, when the Sri Lankan government carried out a programme funded by the IPPF on the social marketing of contraceptives the situation was completely reversed. As a result of this programme, the Pill was re-branded as *Mithuri* (female friend) and became available as an over-the-counter drug. While the shift from *vanda pethi* to *Mithuri* removed the ethnic connotation attached to the Pill, it also put women's bodies at risk as *Mithuri* could be easily accessed without prior medical examination. I seek to examine how this shift manipulated state policy on health, and what this shift tells about women's health and bodies after independence.

Sri Lanka's Role in the Global Pill Trials

The story of the Pill in Sri Lanka commenced with a chance encounter between Dr Siva Chinnatamby and Dr Gregory Pincus. They met in Delhi in 1959 at an international conference on family planning and population control organised by the IPPF. However, this was not actually the chance encounter it may first have appeared. At this conference, Dr Pincus from the Worcester Foundation for Experimental Biology in Shrewsbury, Massachusetts, presented a new invention—

the Pill. This invention was the collective effort of Dr Min-Chueh Chang of the Worcester Foundation and Dr John Rock, an obstetrician-gynaecologist at the Harvard Medical School.³²⁷ Although the invention of the Pill was a collective effort, out of fifteen progestational compounds, it was Pincus who decided on norethynodrel with 1.5 percent mestranol as the oestrogen component.³²⁸ Hence, he was given the honour of presenting the novel findings of their team at the conference in Delhi. Chinnatamby attended this conference in her capacity as the medical director of the Family Planning Association of Ceylon (FPA). Chinnatamby was considered the most suitable representative from Sri Lanka as the government of Sri Lanka had not yet adopted family planning in its agenda.

At the conference, Chinnatamby asked Pincus to assist her in starting a trial of the oral contraceptive pill in Ceylon as she had been dismayed by the fact that 'activities in this field at home had almost come to a stand still.'³²⁹ According to Chinnatamby, there were numerous reports of practical difficulties encountered in the late 1950s, particularly in the slum areas of Ceylon, about existing methods of contraception; i.e., diaphragm, spermicidal jelly, foam tablets and cervical cap. This was due to the lack of privacy for women who had to use common toilets etc. Also, there were difficulties associated with the care and storage of diaphragms,

³²⁷ Within the scientific community Chang was known as 'the sperm man' while Pincus was known as 'the egg man' (Lara Marks, *Sexual Chemistry; A History of the Contraceptive Pill*, New Heaven and London, Yale University Press, 2001, p. 90).

³²⁸ Paul Vaughan, *The Pill on Trial*, London: Weidenfeld and Nicolson, 1970, pp. 31–44 and Marks, *Sexual Chemistry*, p. 107.

³²⁹ Chinnatamby, 'Perspective on Safe Motherhood', p. 7.

namely protecting from crows when drying in the sun and keeping out of the reach of children.³³⁰

As a family planner, Chinnatamby saw the Pill trials as a realistic solution to all the practical difficulties faced by women at home. However, the important question was would the inventors of such a revolutionary scientific technical fix in the US accommodate a request made by the medical director of a family planning association in a tiny country like Sri Lanka?

In order to answer this question I must first provide a brief outline of the invention of the Pill at the Worcester Foundation in Massachusetts; the early pill trials in Puerto Rico, ‘the most studied “underdeveloped” area of the world’; and the intricacies of conducting Pill trials in various other parts of the world.³³¹

The Invention of the Pill at the Worcester Foundation

Apart from the three scientists that I mentioned above, there were two energetic women who encouraged and funded the Pill trials—Margaret Sanger, the founder of Planned Parenthood of America who had an unstinted belief in the oral contraceptive and Katherine McCormick the financial supporter of the Pill.³³²

Min-Chueh Chang, when working on in-vitro fertilisation in 1951, discovered that injecting progesterone could prevent ovulation in rabbits. John Rock experimenting with the effect of progesterone and oestrogen on ovulation

³³⁰ Ibid., p. 6.

³³¹ James Reed, *The Birth Control Movement and American Society From Private Vice to Public Virtue*, New Jersey, Princeton University Press, 1984, p. 359.

³³² Andrea Tone, *Devices and Desires: A History of Contraceptives in America*, New York, Hill and Wang, 2001, p. 204.

and female infertility discovered that these two hormones could not only be used as an inhibitor but also as a contraceptive. After much discussion, Chang, Rock and Pincus began to search for progestational and oestrogen compounds that would be suitable as contraceptives.³³³ Finally, the Pill was patented as 'Enovid' in 1959 and approved by the Food and Drug Administration (FDA) of America the following year.³³⁴ Soon after the invention of the Pill, the team became concerned about its possible carcinogenic effects and decided to include Pap smear testing as a crucial segment of the Pill trials in order to detect cervical cancer.

Since contraceptive research was still illegal in Massachusetts in 1954, 'the Pill team could not conduct large-scale human trials at the beginning,' notes Lara Marks.³³⁵ Furthermore, finding 'suitable research subjects who would be willing to follow complicated rules and undergo intense scrutiny and sometimes even surgical investigation' was very difficult.³³⁶ In her letters to Sanger, McCormick described finding women for the trials a 'headache'.³³⁷ After much discussion and deliberation, the Pill team decided to conduct human trials in New York, Puerto Rico, Japan, Hawaii, India and Mexico.³³⁸ At this stage, Sri Lanka was not on their minds as a possible site for human trials.

³³³ Marks, *Sexual Chemistry*, p. 94.

³³⁴ Vaughan, *The Pill*, p. 31–44 and Marks, *Sexual Chemistry*, p. 107.

³³⁵ Marks, *Sexual Chemistry*, p. 97.

³³⁶ Ibid., p. 98

³³⁷ Ibid., p. 98.

³³⁸ Ibid., p. 98.

The Early Pill Trials

Successful human trials were finally carried out in Rio Piedras, a suburb of San Juan (a new housing project) in Puerto Rico in 1956. The Pill, 'Enovid', produced by G.D. Searle & Company was used in these trials. Although the Pill team originally intended to conduct trials in India, they changed their plan and settled on Sri Lanka as a site for trials. Why? Did India not agree? Weren't large-scale human trials feasible in India? Did the team opt to drop India once Ceylon, India's closest neighbour, volunteered?

According to Lara Marks, while Pincus' Pill was being developed at the Worcester Foundation in Massachusetts, Dr S.N. Sanyal at the Calcutta Bacteriological Institute in India was testing an oral contraceptive in 1949.³³⁹ It was manufactured from the oil of the plant called the *Pisum Sativum Linn*, the common field pea in India. The contraceptive ingredient was Metaxylohydroquinone.³⁴⁰ Sanyal's experiment was funded by the American Philanthropist Dr Clarence Gamble (heir to the Proctor and Gamble soap company fortune). Gamble's mission was 'to find a cheap contraceptive to control the population of the less developed areas of the world.'³⁴¹ His correspondence with John Rock confirms that Pincus did not want to interfere with Sanyal's

³³⁹ Ibid., p. 48.

³⁴⁰ Letter from Dr Sanyal to Dr Clarence Gamble, 29 April 1955, CML of Harvard University, Gamble Papers, Box 81 Folder 1286, and Letter from Dr Gamble to Mr Sherer, 30 June 1960, CML of Harvard University, Gamble Papers, Box 85 Folder 1352.

³⁴¹ For this purpose he placed paid workers at different geographies to work as family planning propaganda officers. One such energetic officer was Margaret F. Roots who worked in Sri Lanka in the mid-1950s. Her reports to Gamble keep him informed of the internal politics and the family planning programme of the country.

contraceptive ingredient—Metaxylohydroquinone. Further, Pincus doubted the scientific basis of the experiment.³⁴² Nevertheless, Gamble became confident of Sanyal's experiments after one of his friends from California did a 'Sherlock Holmes job' for him on Sanyal's trials and verified that the researcher was doing a good job.³⁴³

Though Pincus did not want to interfere with Sanyal's Pill, he was still interested in conducting human trials in India as agreed by the Boston team. The Boston Pill team attempted to launch a trial in India by informing Lady Dhanwanthi Rama Rau, the founder president of the FPA of India, of the success of the Pill experiments. In January 1956, Pincus wrote to Rau: 'The results are extraordinarily uniform and so encouraging that we are planning to go ahead with field trials. The amount of material which is available for testing is at present rather limited, but I may be able to secure enough for tests in India.'³⁴⁴ There is no record of her reply.³⁴⁵ Nevertheless, a month later, Pincus approached Dr John B. Wyon, field director of the India-Harvard-Ludhiana Population Study (commonly known as the Khanna study) to check the possibility of testing one of the two

³⁴² Letter from Dr Clarence Gamble to Dr John Rock, 11 April 1955, CML of Harvard University, Gamble Papers, Box 195 Folder 3084..

³⁴³ Letter from Dr Clarence Gamble to Dr John Rock, 31 March 1955, CML of Harvard University, Gamble Papers, Box 195 Folder 3084.

³⁴⁴ Letter from Pincus to Lady Rama Rau, 3 January 1956, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 23.

³⁴⁵ I did not find her reply in any of the following libraries: Countway Medical Library, Harvard Medical School in Boston, Library of Congress in Washington DC, Rockefeller Archive and Population Council in New York.

newer oral contraceptive substances used in his project.³⁴⁶ However, his request was declined on the 'grounds of safety and effectiveness of the substance.'³⁴⁷

Further attempts to involve India took place in October 1957 when Gamble approached Dr Leroy Allen, a representative of the Rockefeller Foundation in India and former head of Public Health at the Christian Medical College in Vellore in the state of Madras.³⁴⁸ After discussing the matter with Colonel Raina, the family planning officer at the Ministry of Health, Dr Allen wrote back to Gamble in April 1958, that India was 'unlikely to authorise the import of any of the steroids which inhibit ovulation at this time' and was of the opinion that there was 'insufficient information at hand to certify their safety and long term effect.'³⁴⁹ Referring to the correspondence between birth control giants of India, Williams points out that 'the Gandhian legacy' faithfully upheld by Indian officials in the Ministry of Health in the early 1950s 'did not leave space for any form of contraception other than the rhythm method.'³⁵⁰

All evidence points to the fact that the Indian government rejected all requests of the Boston Pill team to conduct Pill trials in India. The government was unwilling to subject women to clinical trials when the safety and long-term

³⁴⁶ Letter from Pincus to Dr John Wyon, 20 January 1956, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 20.

³⁴⁷ Letter from Wyon to Pincus, 27 January 1956, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 20.

³⁴⁸ Letter from Gamble to Pincus, 2 October 1957, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 25.

³⁴⁹ Letter from Gamble to Pincus, 19 May 1958, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.

³⁵⁰ I am grateful to my friend and colleague Rebecca Williams for sharing this information gathered during her PhD research in India.

effect of the Pill was yet unknown. It was then that the Boston Pill team turned to Sri Lanka. In 1959, Sri Lanka volunteered to take up the trials which subsequently commenced in 1961. Dr Chinnatamby's invitation provided an ideal opportunity for the Pill research team to implement clinical trials in Asia considering the similarities between Sri Lanka and India with respect to culture, religion and traditions. As I have outlined in Chapter One, Sri Lanka was well-known as a social laboratory by social scientists across the world from the 1960s.

Once Pincus agreed to shift the trial setting from India to Sri Lanka, Chinnatamby visited the Worcester Foundation in Massachusetts, Puerto Rico and Haiti as a guest of Pincus.³⁵¹ She spent three months in Pincus' unit in Boston studying the Pill trials. On her return to Sri Lanka she was convinced that the Pill was as much the 'answer to our women of lower socio-economic background as it was for those in the West Indies.'³⁵² Chinnatamby's statement clearly demonstrates her eugenicist motives to plan the unplanned families of the destitute in Sri Lanka.

In October 1961, the Pill trials started in Colombo at the family planning clinic of the De Soysa Hospital for Women under Chinnatamby's supervision where she worked as a consultant. In spite of the trials commencing in October, it took six months for Chinnatamby to enrol the first fifty women.³⁵³ Finally, by 1964, two thousand five hundred and twenty eight (2528) women were enrolled

³⁵¹ Chinnatamby, 'Perspective in Safe Motherhood,' p. 7; and Huston, *The Right to Choose*, p. 48.

³⁵² Chinnatamby, 'Perspective in Safe Motherhood,' p. 7

³⁵³ *12th Annual Report of the Family Planning Association 1964-65*, Colombo, FPA, p. 12.

for clinical trials. In this cohort, 49.7 percent of the participants fell into the lower income category, earning less than LKR 100 (approximately 50 pence) per month.³⁵⁴ The Pill was offered free of charge to women who registered for the trials. Chinnatamby explained that a team comprising a 'social worker, midwife, nurse and house surgeon together with the consultant' carried out the trial.³⁵⁵ The information content provided to women participants of the Pill trials and their economic status shows that they were destitute and had limited education. In Chinnatamby's words, 'individual instructions on its use was given to each user by the nurse, house surgeon and myself. Leaflets were distributed to the potential users of the Pill and charts were displayed indicating the details of the regimen of taking it.'³⁵⁶

According to the assistant medical director of G.D. Searle and Company, the first trial Pills used on Sri Lankan women were 2.5 mg tablets of 'Enovid' given cyclically.³⁵⁷ According to Chinnatamby, 'every woman in the trial underwent a routine pelvic examination, examination of breasts, recording of blood pressure and estimation of body weight etc.'³⁵⁸ Since the trials were progressing at a disappointingly slow pace, she invited Pincus to 'come to Ceylon and assist her in the trial.'³⁵⁹ He arrived on 7 March 1962 and delivered several

³⁵⁴ Ibid., p. 12.

³⁵⁵ Chinnatamby, 'Perspective in Safe Motherhood,' p. 9.

³⁵⁶ Chinnatamby, 'Perspective in Safe Motherhood,' p. 7.

³⁵⁷ Letter from J. William Crosson (assistant medical director of G.D. Searle & Co.) to Pincus, 13 June 1961, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 47.

³⁵⁸ Chinnatamby, 'Perspective in Safe Motherhood,' p. 9.

³⁵⁹ Ibid., p. 8.

lectures to scientific organisations and private groups in Colombo.³⁶⁰ Later on, the trials included many types of oral contraceptives, containing different progestogens and varying doses of oestrogen supplied by 'Searle & Company, Organon, British Drug House, London Rubber Company and Wyeth International and Schering' as arranged by Pincus.³⁶¹

It is important, at this stage, to provide a brief background of Dr Siva Chinnatamby, the key person who carried out the clinical trials at the De Soysa Hospital for Women, in order to understand how and on what grounds these trials were conducted in Sri Lanka. Analysing the motives and objectives of different personal affiliations and institutions and how they worked, bargained and negotiated will be useful in order to further understand the planning ideology of the late 1950s and early 1960s, which revolutionised the monitoring of women's bodies.

Dr (Miss) Siva Chinnatamby (1921–2000)

Chinnatamby's encounter with Pincus and her affiliation with the De Soysa Hospital for women—the premier government maternity hospital—paved the way for the clinical trials of the Pill in Sri Lanka. Given her family, educational

³⁶⁰ Ibid., p. 8.

³⁶¹ Siva Chinnatamby, 'Research,' *17th Annual Report of the Family Planning Association 1969–70*, Colombo, FPA, p. 18, and Chinnatamby, 'Role of Research in the FP Movement in Ceylon,' in *Fifteen Years of Family Planning in Ceylon 1953–1968*, Colombo, FPA, p. 46. According to Chinnatamby, the other pills that were tested in Sri Lanka were 'Conovid E', varying doses of Ethynodia Diacetate: 3mg, 2mg, 1mg; Ovulen, Lyndiol: 5mg, 2.5mg; Volidan with varying doses of megestrol with and without oestrogen; Volidan sequential 28; and Feminor, Ovral and Eugynon. *Fifteen Years of Family Planning in Ceylon 1953–1968*, Colombo, FPA, p. 46.

and professional background and exposure, it is not surprising that she took ‘a great step forward in medical science in Sri Lanka.’³⁶² She was a modern woman who believed in scientific inventions and had the courage to apply them to support Sri Lanka’s pursuit of development in the 1960s.

Siva Chinnatamby was born in 1921 in the northern city of Jaffna, the ‘capital’ of ethnic Tamils in Sri Lanka. She belonged to a wealthy Jaffna Hindu Tamil *Vellala* family.³⁶³ She was educated at the Ramanathan College for Girls in Chunnakam, Jaffna. Many at the time regarded this school to be the premier educational institution for girls in Jaffna. Her father was Gate Mudliyar K. Chinnatamby, a government servant in the colonial administration.³⁶⁴ She was the youngest of five children. Both her elder sisters died in their early twenties after giving birth to their first born.³⁶⁵ According to Huston, the death of Chinnatamby’s sisters planted the seeds for her determination to ‘contribute to the reduction of maternal and child mortality’ in Sri Lanka.³⁶⁶

³⁶² Interview with the successor of Chinnatamby (former medical director) at the FPA, 16 Feb. 2010, at her residence in Colombo.

³⁶³ The *Vellala* caste members in the Tamil community are primarily cultivators as *Goyigama* caste members in the Sinhala community. *Vellala* is a dominant Tamil caste constituting well over 50 percent of the Tamil population. Today the *Vellala* community still comprises a large portion of the Tamil urban middle class. In the past, the *Vellala* formed the elite in the Jaffna kingdom and were the larger landlords; during the colonial period, they took advantage of new avenues for mobility and made up a large section of the educated, administrative middle class. (http://www.lankalibrary.com/cul/jaffna_castes.htm and <http://www.defonseka.com/k07.htm>, accessed on 1 October 2012).

³⁶⁴ <http://sundaytimes.lk/000109/plus10.html> (Accessed on 25 October 2011). Gate Mudliyar is a title given to locals who have served the British government with great loyalty. This class resembled the English country squires. http://en.wikipedia.org/wiki/Sri_Lankan_Mudaliyars (Accessed on 2 Oct 2012).

³⁶⁵ Perdita Huston, *Motherhood by Choice; Pioneers in Women’s Health and Family Planning*, The Feminist Press, New York, IPPF, 1992, p. 49.

³⁶⁶ Ibid., p. 49.

Although Chinnatamby belonged to a very traditional family, her educational attainments and social status paved the way for her to be independent, disregarding the social norms of the day. After completing her secondary education at Ramanathan College, she entered the Medical Faculty of the University of Colombo. Colombo, the capital city, was considered the heart of the ethnic Sinhala community in Ceylon. She was one of five female medical students out of a total of nine in her batch to qualify as medical doctors. Chinnatamby was the only student to specialise in gynaecology.³⁶⁷

Chinnatamby's first experience in obstetrics started in 1947 when she took up the post of house surgeon at the De Soysa Hospital for Women in Colombo.³⁶⁸ After completing her post-graduate training in the UK, she returned to Ceylon in 1953 and was appointed as a consultant at the same hospital.³⁶⁹ She was also appointed as the medical director of the FPA of Ceylon, a post she held for 25 years.³⁷⁰ She accepted the latter position only on the condition that she be allowed to practice her speciality—infertility. This was a rather unusual speciality to have in the 1950s, particularly in the field of family planning in one of the most populated regions of the world. In the early 1960s, she directed clinical trials of the Pill and Intra Uterine Devices, and worked towards creating, 'a momentum for family planning as a health activity in Sri Lanka.'³⁷¹

³⁶⁷ <http://sundaytimes.lk/000109/plus10.html> (Accessed on 16 July 2012).

³⁶⁸ Chinnatamby, 'Perspective in Safe Motherhood', p. 2.

³⁶⁹ Ibid., p. 4.

³⁷⁰ <http://www.island.lk/2001/02/22/opinio07.html> (Accessed on 25 Oct. 2011).

³⁷¹ Interviewed the former Dean of the Faculty of Medicine, University of Colombo, (Chinnatamby's student in the 1970s) on 9 June 2010 and emailed on 2 October 2011.

Even though Chinnatamby retired from government service in February 1965, she carried on with the FPA's work in an honorary capacity and continued her research with international institutions and researchers.³⁷² Apart from her affiliations with the De Soysa Hospital and the FPA, she also carried out a private practice at her residence in Colombo 7 where she catered exclusively to upper middle class women.³⁷³ She was the main female gynaecologist in the 1960s and 1970s with a clientele from every strata of society.³⁷⁴ She was one of the founding members of the Ceylon College of Obstetricians and Gynaecologists established in 1967, and worked as the founder-secretary of the college during its infancy.³⁷⁵ She was the first woman in Ceylon to be appointed a fellow of the American College of Surgeons in 1966.³⁷⁶ She also served as the president of the Asia and Oceania Federation of Obstetrics and Gynaecology from 1987 to 89.³⁷⁷

A brief history of the venue—De Soysa Maternity Hospital for Women—will be helpful in order to understand the context in which the clinical trials of the Pill took place, in 1961. The De Soysa Hospital for Women plays a rather paradoxical role in the history of the Pill in Sri Lanka as it was a government hospital that nevertheless became the site for a medical initiative conducted by an NGO. Chinnatamby was the one who brought about this paradox as she was

³⁷² Letter from Chinnatamby to Pincus, 5 February 1965, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.

³⁷³ Colombo 7 is a well sought after residential neighbourhood inhabited by the upper middle class who earned their wealth through colonial trade in the early 1900s.

³⁷⁴ Attested to by one of my aunts who remembered Dr Chinnatamby as a close friend of her father's (a gynaecologist in 1950–60s) (5 December 2010).

³⁷⁵ <http://www.island.lk/2001/02/22/opinio07.html> (Accessed on 30 Oct. 2011).

³⁷⁶ 'Triple Honour', *Ceylon Observer*, 15 April 1966, p. 6.

³⁷⁷ <http://www.aofog.org/past-officers> (Accessed on 25 Oct. 2011).

affiliated to both these institutions—the De Soysa Hospital for Women and the FPA.

The De Soysa Lying-in-Home

At a time when hospital facilities were still rudimentary in Sri Lanka and the infant mortality rate was 60 to 65 per 1000 live births, Sir Charles Henry de Soysa, a philanthropist from Moratuwa (a southern suburb of Colombo) built the first maternity hospital in Sri Lanka by donating a part of his house in Colombo. This came to be known as the De Soysa Lying-in-home.³⁷⁸ The 65-bed lying-in-home was opened on 9 December 1879 by the governor of Ceylon Sir J.R. Longden.³⁷⁹ By its centennial the De Soysa hospital had increased its bed strength to 347.³⁸⁰ It is now considered to be the second oldest maternity home in Asia.³⁸¹ Charles De Soysa, who was from an upper class *Karava* (second highest in the Sinhala caste hierarchy) family from Moratuwa, earned his wealth during the colonial period through his coffee plantations and trading activities.³⁸² Many members of the *Karava* community engaged in social work such as building educational

³⁷⁸ In 1940, it was renamed as De Soysa Maternity Home and in 1950 it was renamed again as De Soysa Hospital for Women.

³⁷⁹ Thilaka Pancharatnam, '100 years of maternity care', *The Sunday Times*, 25th Nov. 1979, p. 8.

³⁸⁰ *Ibid.*, p. 8.

³⁸¹ <http://www.rootsweb.ancestry.com/~lkawgw/desoysah.htm> (Accessed on 25 Oct. 2011).

³⁸² <http://www.rootsweb.ancestry.com/~lkawgw/karava.html> (Accessed on 29 Oct. 2011) and <http://www.infolanka.com/org/srilanka/people/81.htm> (Accessed on 10 Aug. 2010).

institutions and hospitals, during this period, by using the wealth they had amassed through colonial trade.³⁸³

Dr A.M. Fernando was appointed the first medical superintendent of the hospital in 1887. The first caesarean delivery in Sri Lanka was also performed at this hospital in 1905. It was the premier training institute in midwifery by 1909 and also a training institute for medical students specialising in obstetrics and gynaecology by 1915, and nursing by 1916. It continues to be the foremost training institute for obstetrics and gynaecology even today. In 1921, it housed Asia's first ante-natal clinic. The FPA of Ceylon opened the first family planning clinic, appropriately called 'Mothers' Welfare Clinic', at the De Soysa Hospital for Women on 2 September 1953. By then Chinnatamby was performing a dual role as consultant at the De Soysa Hospital for Women and as the medical director of the FPA, an informal welfare organisation founded by a group of elite Sri Lankan women.³⁸⁴

With the opening of the 'Mothers' Welfare Clinic' in 1953 and conducting the Pill trials in 1961, the De Soysa Hospital became a site of paradox. Though the government had not yet taken family planning on its agenda, the premier government maternity hospital ended up housing the two most crucial family planning initiatives—the 'Mothers' Welfare Clinic' and the Pincus Pill trials—

³⁸³ See Jayawardene's *Nobodies to Somebodies*, 2000, for a comprehensive analysis of *Karava* community in Sri Lanka.

³⁸⁴ Chinnatamby, 'Perspective in Safe Motherhood,' p. 4–5.

conducted by the FPA of Ceylon.³⁸⁵ As I have pointed out in Chapter One, the government's stand on family planning was not explicitly put forward until 1965. However, it supported the cause of family planning in the name of population control seen as a development imperative by the 1950s. The functions of these two institutions (the government and the FPA) merged at some points and diverged at others. Chinnatamby's affiliation to both these institutions made the Pill trials feasible and unproblematic at the De Soysa Hospital. Since the government acknowledged family planning as a development imperative in the name of population control, the Pill trials did not face any difficulties in this arena. Interestingly, an unmarried Tamil female consultant gynaecologist conducted the Pill trials with the aim of contributing to global research on the production of an effective oral contraceptive, in the hope of using this in turn to plan the unplanned families of Sri Lanka. For this purpose, Chinnatamby was able to weave the government and the FPA together for the cause of family planning as a development imperative.

Meanwhile, at the global level, it was crucial for the Boston team to conduct Pill trials at different geographic locations in order to minimise the possible side effects and produce the most effective Pill. This became the imperative by late 1962 with the FDA 'receiving reports of twenty six women who had suffered from blood clots in their veins (thrombophlebitis), six of whom

³⁸⁵ The FPA became an approved charitable institution only in 1965.

died.’³⁸⁶ The failure of even one clinical setting to produce results meant a negative impact on the final result and decision of the Boston team. Did Chinnatamby manage to conduct Pill trials according to the criteria set by the Boston team?

The Failure of Pap Smear Slides

Pap smear testing is used in clinical trials to detect carcinogenic effects of the studied substance. Pincus arranged to do the Pap smear tests of Sri Lankan women at the Worcester Foundation as Sri Lanka did not have Pap smear testing facilities in 1961. From June 1961 onwards, Chinnatamby was sending smear slides to Pincus for testing.³⁸⁷ Chinnatamby claimed in 1964 that there was ‘not a single report from Worcester Foundation indicating any complications on Pap smear examinations.’³⁸⁸ In spite of all efforts, from the correspondence of Chinnatamby, Pincus and Pincus’ cytotechnologist, Donna-Drew O’Connell, between 1964 and 1966, it is evident that the smear slides sent from Ceylon were ‘unsatisfactory and could not be examined.’³⁸⁹

In January 1964, Pincus wrote to Chinnatamby that ‘it is very sad for us to process a whole batch of slides and find a large proportion of them in such bad

³⁸⁶ Marks, *Sexual Chemistry*, p. 138.

³⁸⁷ Letter from Ruth Crozier (Pincus’s secretary) to Chinnatamby, 16 June 1961, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 47.

³⁸⁸ Chinnatamby, ‘Perspective in Safe Motherhood,’ p. 9. See also Chinnatamby, ‘Oral Contraceptives,’ in *11th Annual Report of the Family Planning Association of Ceylon 1963–64*, Colombo, FPA, 1964, p. 31.

³⁸⁹ Letter from Pincus to Chinnatamby, 26 January 1964, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95 and Letter from Donna-Drew O’Connell to Chinnatamby, 6 April 1966, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.

shape.³⁹⁰ In her reply to Pincus, Chinnatamby mentioned a number of reasons and obstacles she had encountered that resulted in the production of poor slides. Namely, not having the slide containers available on time (they were sent from Boston by post), delays in export permits, port strikes, postal irregularities and the use of the same bottle of lotion for more than one set of slides in order to be more economical.³⁹¹ However, in February 1964 he wrote again to Chinnatamby saying that ‘if the material is properly fixed the slides should be good for a long time,’ which suggests that he chose to disregard Chinnatamby’s complaint about the delay of slide containers to reach Ceylon and chose instead to highlight shortcomings in the fixing of the slides.³⁹² In 1966, O’Connell wrote to Chinnatamby in a rather exasperated tone:

I regret to inform you that, as of this date, this laboratory will not be reading your slides since the fixation is *still* (emphasis mine) extremely poor. If any new method of fixation is used or the present method is improved, please notify me and we will gladly evaluate the slides.³⁹³

The stress on the fixation of slides being ‘still extremely poor’ in the letter above clearly demonstrates that Chinnatamby had failed, even after two years (between January 1964 and April 1966), to meet the standards for cytology testing when obtaining Pap smears, required by the Boston team. As a result, Sri Lanka could

³⁹⁰ Letter from Pincus to Chinnatamby, 26 January 1964, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.

³⁹¹ Letter from Chinnatamby to Pincus, 3 February 1964, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95. And Letter from Chinnatamby to O’Connell, 22 April 1966, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95..

³⁹² Letter from Pincus to Chinnatamby, 10 February 1964, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.

³⁹³ Letter from Donna-Drew O’Connell to Chinnatamby, 6 April 1966, The LOC, Washington DC, Manuscript Division, Gregory Pincus Papers, Box 95.

not serve as a full-fledged trial site for the Boston team. It is therefore questionable whether Sri Lanka contributed to the global Pill trials in any meaningful way.

Although Chinnatamby's efforts in contributing to global Pill trials were not entirely satisfactory, the Pill trials certainly established a link between the FPA and the government. It also paved the way for the government to adopt the agenda of family planning, in 1965.

The Emergence of the Pill as the Best Tool to Plan the Unplanned Families of Sri Lanka

In spite of the Pill being available in Sri Lanka from 1961, samples of Sri Lankan women were not tested for any carcinogenic effects since the Pap smear slides sent for analysis did not meet the standards for cytology testing. However, by 1963, 'the Ceylon Hospital Drug Committee agreed to include oral pills in the Hospital Formulary, disregarding the impending carcinogenic effects of the Pill.'³⁹⁴ According to Professor Ranasinghe, the head of the Hospital Drug Committee at that time, there were fourteen brands of pills available in Sri Lanka by 1970.³⁹⁵ Can we infer that the Ceylon Hospital Drug Committee made the health of Sri Lankan women vulnerable by importing pills (developed by foreign pharmaceutical companies) that were not tested in Sri Lanka for possible carcinogenic effects?

³⁹⁴ De Silva (ed.), *A History of Family Planning in Sri Lanka 1953–1978*, p. 119.

³⁹⁵ 'Pill Safe', *The Ceylon Daily News* 11th Feb. 1970, p. 7.

This omission was not surprising considering the articles that appeared in Sinhalese newspapers with reference to the Pill. Questions regarding women's health concerns were never raised by the Sinhalese media although English newspapers reproduced foreign press reports on the carcinogenic effects and thrombosis associated with the Pill based on research carried out in the United States and Europe.³⁹⁶ The Sinhalese newspapers saw the Pill *only* as a weapon and a tool to disturb the ethnic balance of the country, hence the coinage of the term *vanda beheth/pethi* (sterility pills).

Women's bodies have been and continue to be seen only as reproductive machines important in influencing population growth and census reports, rather than as corporeal entities with their own needs and desires. A woman's health was a matter of concern to the state as long as her reproductive body was in control. The state used the Pill, in line with the dominant planning ideology of the mid-1960s, to plan the unplanned families of Sri Lanka at the expense of women's health.

Furthermore, medical professionals in Sri Lanka encouraged women to use the Pill while evading questions regarding its safety because the Pill seemed an effective method of family planning in Sri Lanka in the late 1960s. Professor Ranasinghe deliberately evaded the question whether the Pill led to thrombosis by claiming: 'Chances of getting thrombosis during pregnancy are greater because

³⁹⁶ 'The Pill: No evidence of danger, says BMJ,' *Ceylon Daily News*, 17 February 1970, p. 1.

pregnancy itself can bring on thrombosis.’³⁹⁷ On the other hand, Sinhalese Buddhist extremists saw the Pill not as a health hazard to women but as a modern, Western, imperialist tool to reduce the majority race to a minority.³⁹⁸ Both medical professionals and Sinhalese Buddhist extremists were trying to manipulate women’s bodies for their own agendas. As a result, they have failed to see the health implications of the Pill for women.

Medical professionals and family planners of Sri Lanka were convinced that the clinical trials and the introduction and delivery of the Pill were a timely endeavour to plan the unplanned families of Sri Lanka. However, the Sinhalese Buddhist extremists of the late 1960s saw the Pill as a weapon that could disturb the ethnic balance of the country. They carried out a vociferous discussion on family planning, population growth and contraception linked to ethnicity, development and modernisation in the Sinhala newspapers *Silumina* and *Dinamina* in the late 1960s. As mentioned above, Sinhalese Buddhists termed the Pill *vanda beheth/pethi* by the late 1960s. Yet, less than five years later, by the mid-1970s, the Pill was re-branded *Mithuri* (female friend) as a result of an IPPF marketing programme and subsequently became an over-the-counter drug. How should we understand this shift? How did the Sinhalese Buddhist extremists react to this about-turn?

³⁹⁷ ‘Pill Safe’, *The Ceylon Daily News*, 11 February 1970, p. 7.

³⁹⁸ ‘*Upath Palanaya Sinhalaayan Vanda Kirimakda?*’ (Does Birth Control suggest the Extinction of the Sinhala Race?), *Silumina*, 12 August 1969, p. 13

The second part of the chapter examines how women's bodies were manipulated through this shift in terminology from *vanda beheth/pethi* to *Mithuri*. Even though the term *vanda beheth/pethi* is dismissed by today's family planners and gynaecologists, the change in terminology speaks volumes about the way women's bodies were framed within Sinhalese Buddhist nationalist discourse at this particular moment in the history of independent Sri Lanka.³⁹⁹ *Vanda beheth/pethi* was a derogatory term with a negative connotation in the nationalist discourse, while *Mithuri* became a positive term with a broader scope in development discourse. What does this shift suggest? Did *Mithuri* silence the ethnic connotation attached to the Pill and gave it a new image? If so, what happened to women's health and bodies during this silencing process? Did *Mithuri* silence women's agency in the matter of their health and bodies in the name of development? I will be probing into the nature of this shift by answering these questions in the second part of this chapter. I commence with my first encounter with the term *vanda beheth/pethi* in Sinhalese newspapers in the late 1960s and will examine different connotations attached to *vanda beheth/pethi*. Understanding this term is of significance to the story of the Pill, because it came into being when discourses on women's bodies for the first time framed a women's health initiative through the introduction of the Pill in Sri Lanka.

³⁹⁹ Family planners spoke about the term *vanda beheth/pethi* in a rather disgusted tone during their interviews with me.

Women's Bodies and the Framing of Contraceptive Discourses

I first came across references to birth control pills as *vanda pethi* (sterility pills) in September 2010, when I was doing archival research at the National Archives of Sri Lanka in Colombo. I discovered that this term had first been used in 1969 in the *Silumina*, the most widely circulated Sinhalese newspaper of the time. I was bemused and bewildered by such a term used for the Pill. I also encountered the term in another Sinhalese newspaper dating from 1970. This article was headlined in bold letters: *Vanda Behethvalin Sinhala Jathiya Sulu Jathiyak Venawa: Eya Vahama Nathara Karranna* [Sterility Pills will reduce the Sinhalese race to a minority: It should be stopped immediately].⁴⁰⁰

The term *vanda beheth/pethi* made me wonder whether there had been a more colloquial term for the Pill. Nothing came to my mind other than *Mithuri* (female friend).⁴⁰¹ I asked my immediate female family members—my mother, mother-in-law and aunts—of another more colloquial term, to which they all answered ‘*upath palana pethi*’ which literally means birth control pills. Then I told them about my archival research finding (*vanda pethi/beheth*) and to my amazement they were not surprised. My mother-in-law (born in 1942) casually said, ‘oh yes, the Pill was commonly called *vanda pethi* in our village those days.’

⁴⁰⁰ Reporter, Sub Urban Council, Polgahawela, ‘*Vanda Behethvalin Sinhala Jathiya Sulu Jathiyak Venawa: Eya Vahama Nathara Karranna*’ [Sterility Pills will reduce the Sinhalese race to a minority: It should be stopped immediately] *Dinamina*, 1 January 1970, p. 5. The term *vanda beheth* had been used at a sub-urban council meeting at Polgahawela; a town in the western province.

⁴⁰¹ Since I was born in 1975, during my early teens *Mithuri* had become a household name in Sri Lanka. So it was not surprising that I could not think of any other colloquial term for *vanda beheth/pethi*.

Similarly, my mother (born in 1946) said, ‘yes, I remember, we (meaning her three sisters in their early twenties) used to laugh at *Ananda ayya*, (their brother-in-law, who was a medical officer between 1965 and 1970 in a small village in the western province of Sri Lanka) when he used the term *vanda pethi* when instructing midwives of the area on its use and distribution.’ I queried as to why they had laughed at the term. ‘Don’t you think it is a very *gode* (unrefined) word to be used by a doctor?’ she asked me. ‘So did he refine it after you teased him?’ I asked, thinking her answer would be in the affirmative. But, I was wrong. He had told her even though *vanda pethi* sounds *gode* (unrefined), that is what it was commonly referred to in Sinhalese so he had to use it when conversing with midwives. This anecdote suggests that *vanda pethi* was the term commonly used for the Pill among the rural peasantry of Sri Lanka in the 1960s.

I checked the usage of *vanda pethi* with the medical director of the Family Planning Association (FPA), the director of family planning at the Ministry of Health and the former dean of the Faculty of Medicine. They all stated very authoritatively that ‘the Sinhalese term for the Pill is *upath palana gilina pethi* (oral birth control pills).’ I asked them whether they had come across the term *vanda pethi/beheth* at any point in their career as medical professionals, especially when they had served in different parts of the country. They all responded in the affirmative, but then the former dean added, in a rather contemptuous tone: ‘Oh! The Sinhalese (meaning extremists) are very good at creating sensational terms.’ He sounded as if this negative connotation attached to the Pill was merely an

outrageous idea created by extremist Sinhalese nationalists and had no wider influence. The Ministry of Health official described it as ‘journalistic rubbish.’⁴⁰² But was it merely ‘journalistic rubbish’? Prof Laksiri Jayasuriya, head of the Department of Sociology at the University of Colombo, also referred to the Pill as *vanda pethi* in an interview given to the *Silumina* in 1969 on whether sex education should be incorporated into the school curriculum.⁴⁰³

What do all these anecdotal and archival accounts point to? Undoubtedly, *vanda pethi/beheth* was the Sinhalese colloquial term for the Pill but today the term sounds repulsive, especially to medical professionals who work in the field of family planning. Is it because they now have a better term, *Mithuri*, to refer to the Pill, or did they disapprove of the link between women’s bodies and the proposed ethnic imbalance that *vanda pethi* suggests? As a historian I am not ready to shrug off *vanda pethi* or *beheth* as ‘journalistic rubbish’, because for me this intriguing term suggests a vexed connection between Sinhalese Buddhist nationalism, women’s bodies, development and modernisation.

***Vanda Beheth/Pethi* Connotes ...**

Three implied, interrelated meanings for the term *vanda beheth/pethi* can be seen in the newspaper discussions on contraception. It is important to first smoothen

⁴⁰² Little did they know that some militant African Americans had also perceived the tool as a ‘genocidal weapon’ and ‘racist tool’ in the 1970s (see Elizabeth Siegel Watkins, *On the Pill: A Social History of Oral Contraceptives 1950–1970*, Baltimore and London, The John Hopkins University Press, p. 56).

⁴⁰³ Lakshman Jayawardena, ‘*Lingika Vidyawa ha Tharuna Parapura*’ (Sexual Science and the Younger Generation), *Silumina* 3 September 1969, p. 13.

the rough edges of the Sinhalese term for the Pill, in order to understand how women's bodies framed the basis of this shift from *vanda beheth/pethi* to *Mithuri*.

First, *vanda beheth/pethi* addressed the literal meaning of 'sterility pills' which is understood in terms of impairing the growth of the population. Sinhalese nationalists became suspicious of the Tamil minority as an impending threat to the ethnic balance similarly to the way the West viewed increasing populations as a Communist threat during the Cold War in the 1950s. The fear of impending ethnic disproportion was voiced in the Sinhala daily *Dinamina*, giving prominence to numerical aspects of the population: 'it will reduce the majority to a minority.'⁴⁰⁴ After the Sinhala Only Act of 1956, Sinhalese Buddhist nationalism emerged with a new vigour, supported by Prime Minister . S.W.R.D. Bandaranaike's five great forces: *sanga* (Buddhist monks), *veda* (Ayurvedic physicians), *guru* (school teachers), *govi* (farmers), *kamkaru* (labourers).⁴⁰⁵ Two of these forces namely, Buddhist monks and school teachers, who were revered as upholders of traditional culture, contributed to the newspaper discussion on contraception with a strong Sinhalese Buddhist chauvinistic outlook. Another force, the Ayurvedic physicians, were organised by the *Mithuri* programme to take the Pill to the rural masses by the late 1970s. The consequence of the Bandaranaike regime of 1956 was succinctly described by Uyangoda as 'the rapid Sinhalisation of the post-colonial state in a framework of Sinhalese-Buddhist

⁴⁰⁴ Reporter, Sub Urban Council, Polgahawela, '*Vanda Behethvalin Sinhala Jathiya Sulu Jathiyak Venawa: Eya Vahama Nathara Karranna*' (Sterility Pills make Sinhalese a minority: It should be stopped Immediately), *Dinamina* 1 January 1970, p. 5.

⁴⁰⁵ All these five social categories are essentially Sinhalese Buddhists.

cultural identity.’⁴⁰⁶ This chauvinistic Sinhalisation process was well documented in newspaper discussions on contraception in the late 1960s.

By the mid-1960s, the state was also attempting to define the development agenda for the Sinhalese Buddhist nation-state. After the assassination of Prime Minister Bandaranaike in 1959, the *Ten Year Plan* (1959–69), which experts claimed was an excellent development plan, did not make as much progress as hoped. What did development mean for the Sinhalese Buddhist nation of Sri Lanka? The reduction of the population growth rate seemed the most viable way ahead. However, since it was the Sinhalese Buddhist nation and not the wider nation that had to be developed, nationalists described the Pill as *vandal beheth/pethi* to suggest that the Pill should not be taken by Sinhalese Buddhist women (but rather by women of other ethnic groups). In this way, the Sinhalese Buddhist nation should be the beneficiary of the fruits of development born by population reduction. The ethnicity and marital status of the pioneer of the Pill, Dr Chinnatamby, an unmarried Tamil woman, added strength to the claims of Sinhalese Buddhist extremists that the Pill was a weapon to disrupt the ethnic balance of the country.

⁴⁰⁶ S. Bastian, S. Kottegoda, C. Orjuela and J. Uyangoda *Power and Politics in the Shadow of Sri Lanka's Armed Conflict*, SIDA Studies No. 25, 2010, p. 40. http://www.niaslinc.dk/gateway_to_asia/nordic_webpublications/x400249129.pdf (Accessed on the 7 Nov. 2011).

Chinnatamby as Mother of *Vanda Beheth* in Sri Lanka

What was the impact of the clinical trials of the Pill undertaken by an unmarried Tamil female gynaecologist in a predominantly Sinhalese Sri Lanka, particularly after the Sinhala Only Act in 1956 and the anti-Tamil riots in 1958?⁴⁰⁷ The Sinhala Only Act replaced English as the official language of Ceylon with Sinhala and simultaneously deprived official status to Tamil, the language of the minority community. This move was opposed by Tamils who requested that Tamil be declared as the administrative language in the predominantly Tamil-speaking northern and eastern regions of the island. This resulted in the Bandaranaike–Chelvanayakam pact of 1957. However, Bandaranaike was forced by Sinhalese nationalists to cancel the pact in 1958, which led to the first island-wide, anti-Tamil riots after independence. It is against such a backdrop that Sinhalese nationalists sought to cast suspicion on the link between Chinnatamby's ethnic identity and the oral contraceptive introduced by her, which they perceived as a weapon to make Sinhalese women sterile.⁴⁰⁸

But why shouldn't Chinnatamby involve herself in clinical trials? As previously mentioned, she was the medical director of the FPA who attended the IPPF conference in Delhi and met Dr Pincus. Considering her official position, she was the most suitable person to launch such an initiative. Furthermore, her affiliation to the premier government maternity hospital, the De Soysa Hospital

⁴⁰⁷ The anti-Tamil riots of 1958 are popularly known as *Shri* riots.

⁴⁰⁸ Madihe Pagnaseeha Thero, '*Upath Palanaya Sinhalaayan Vanda Kireemakda?* (Does Birth Control suggest the extinction of the Sinhala Race?), *Silumina*, 12 August (Tuesday), 1969, p. 3.

for Women, provided her with a perfect location to conduct the clinical trials of the Pincus Pill. Indeed, this undertaking was a medical victory in the eyes of the family planners and medical professionals of Sri Lanka. It is clear from my interviews with Chinnatamby's colleagues that they harboured no doubts concerning her decision to take up the Pill trials. Chinnatamby's successor at the FPA, saw it as a 'great step forward in medical science in Sri Lanka.'⁴⁰⁹ The former dean of the Faculty of Medicine and one of Chinnatamby's students in the early 1970s, observed that she created a 'momentum for family planning as a health activity in Sri Lanka.'⁴¹⁰ In fact, Chinnatamby is fondly remembered by contemporary medical professionals in Sri Lanka as the 'Mother of the Pill'.

Chinnatamby's upper class family background, education (alumna of Ramanathan College in Jaffna), profession (gynaecologist) and international exposure enabled her to become a capable and competent woman worthy of undertaking a modern scientific project such as the Pill trials. Her voluntary effort in conducting Pill trials could be best analysed through Scott's concept of 'high-modernist ideology' which he defines as:

[A] strong sense of self confidence about scientific and technical progress, the expansion of production, the growing satisfaction of human needs, the mastery of nature (including human nature), and above all, the rational design of social order commensurate with the scientific understanding of natural laws.⁴¹¹

⁴⁰⁹ Interview with the former medical director of the FPA 16 Feb. 2010 at her residence in Colombo.

⁴¹⁰ Interview with former Dean, Faculty of Medicine, University of Colombo on 9 June 2010 and emailed on the 2 October 2011.

⁴¹¹ James Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*, New Haven & London, Yale University Press, 1998, p. 4. In his analysis on failure of the human development schemes, Scott points out four elements which make this failure happen. They

In the late 1950s, Chinnatamby was dismayed by the practical difficulties of existing methods of contraception and as the medical director of the FPA she had identified that the time was ripe to introduce a modern contraceptive method to Sri Lanka.⁴¹² Pincus' Pill trials came about at a moment when Sri Lanka was in need of a modern, scientific and technical solution for existing problems in family planning activities. Chinnatamby thus saw the Pill as the best scientific invention to 'master' the human nature of reproduction by planning the unplanned families of Sri Lankans in order to make the country into a development 'model' for South Asia. At that time, Sinhalese Buddhists portrayed Chinnatamby as someone attempting to disturb the ethnic balance of the country by using *vanda beheth/pethi* as a weapon. However, when delving into the historiography of the Pill trials in Sri Lanka, it becomes evident to me that the question at stake was not Chinnatamby's ethnicity but women's health. The real issue at stake was the jeopardy of women's health by market forces by producing the conceptual shift from *vanda beheth/pethi* to *Mithuri*. I will deal with this question in the next section after analysing the other two connotations of *vanda beheth/pethi*.

The first connotation of *vanda beheth/pethi* addressed the quantitative aspect of population, while the second refers to its qualitative aspect which links culture, morality and civility. *Vanda beheth/pethi* was the perceived instrumental

are, administrative ordering of nature and society, high-modernist ideology, authoritarian state and prostrate civil society.

⁴¹² Chinnatamby, 'Perspective in Safe Motherhood', p. 6.

cause in the degeneration of the Arya Sinhalese Buddhist race by allowing people to indulge in sexual activities for carnal pleasures while enabling them to escape moral obligations and responsibilities towards the nation.⁴¹³ This weighed heavily on women as I have pointed out in my introductory chapter; it was women's duty to uphold tradition, inculcate good morals in children and regenerate the nation. The view expressed by both the Buddhist and the Catholic clergy was that 'married life is not merely having pleasure in the sexual act but is a great responsibility which requires self-restraint and self-discipline, only then can a nation with high moral values develop.'⁴¹⁴ The chief prelate of the Sri Amarapura Dhammarakshita Nikaya,⁴¹⁵ and one of the most vociferous monks of the day, Madihe Pagnaseeha Thero, was predicting in 1969 that the *vanda pethi* would make Sri Lanka a sterile civilisation in twenty-five years.⁴¹⁶ By naming the Pill *vanda beheth/pethi*, these Sinhalese Buddhist extremists intended not only to reduce the number of people using contraception but also hoped to prevent people from indulging in carnal pleasures. For example, Professor Siri Seevali Thero (former dean of the Buddhist Faculty at Vidyalandara Pirivena in 1969) openly advocated that the best method of birth control was sexual abstinence. He further explained that other birth control (*upath palana*) methods which prevented

⁴¹³ Lakshman Jayawardena, 'Lingika Vidyawa ha Tharuna Parapura' (Sexual Science and Young Generation), *Silumina* 3 (Wed) Sep. 1969, p. 13.

⁴¹⁴ Lakshman Jayawardena, 'Obata Daruwan Epada' (Don't you want Children?), *Silumina*, 20 August 1969, p. 13.

⁴¹⁵ There are three Chapters (*Nikayas*) in Buddhist priestly order in Sri Lanka based on caste. *Amarapura Nikaya* is the one where non-*govigama* priests take ordination.

⁴¹⁶ Madihe Pagnaseeha Thero, 'Upath Palanaya Sinhala Vanda Kirimakda?' (Does Birth Control suggest the Extinction of Sinhala Race?), *Silumina*, 12th August (Tue) 1969, p. 13.

women from conceiving (*upath valakveemaki*) were not acceptable according to Buddhist philosophy.⁴¹⁷

Professor Laksiri Jayasuriya, head of the Department of Sociology, University of Colombo, noted in the 1960s that '[i]t is very important for the youth to be aware of sexual activities, in order to lead a happy married life. ... Then *sterility pills* (emphasis mine) are not needed for population control, it only makes women promiscuous.'⁴¹⁸ What does this statement suggest? It suggests that the Pill was perceived as an agent of immorality and corruption that would transform the Sinhalese Buddhist nation into an uncivilised state. In other words, the extremists saw the Pill as a licence for women to be free from traditionally and culturally disciplined bodies.

The third connotation of *vanda beheth/pethi* was the repugnance of nationalists of the 1960s towards the Pill as a modern Western product. This led to its violent refusal, as nationalists abhorred anything originating in the West. Thus, by using the term of abhorrence, *vanda beheth/pethi*, they sought to keep the Pill (a Western product) out of the 'inner' domain or 'spiritual essence' of the nation. When the Pill was introduced in 1961, the FPA was severely criticised by the Sinhalese Buddhist nationalists for being an organisation set up by Westernised women in order to corrupt Sinhalese Buddhist culture. Madihe

⁴¹⁷ Lakshman Jayawardena, 'Obata Daruwan Epada' (Don't you want Children?), *Silumina*, 20 (Wed) August 1969, p. 13. Vidyalankara Pirivena was originally a university for Buddhist monks, founded in 1875. Today it is a fully fledged state university and its name was changed to University of Kelaniya.

⁴¹⁸ Lakshman Jayawardena, '*Lingika Vidyawa ha Tharuna Parapura*' (Sexual Science and Young Generation), *Silumina* 3 September 1969, p. 13. (The English translation from Sinhalese is mine)

Pagnaseeha Thero called the FPA a ‘devious organisation’ (*Koota Vyaparayaki*) established by a handful of upper class Catholic women to make the Sinhalese Buddhists a minority.⁴¹⁹ He considered the FPA to be a counterfeit organisation framed within modern Western thinking which was working towards making the Sinhalese race extinct in Sri Lanka.

The premise of these three connotations of *vanda pethi*—the quantitative and qualitative aspects of population and its use as an expression of repugnance—was the overarching theme of nationalism which had and continues to have an intrinsic link to women’s bodies in Sri Lanka as the site of national and cultural reproduction. Having set out the link between women’s bodies and the different connotations of *vanda beheth/pethi*, mobilised by Sinhalese nationalists in the 1960s, I will now examine the shift from *vanda beheth/pethi* to *Mithuri*. How did the Pill that was once contemptuously rejected as *vanda beheth/pethi* become a woman’s female friend or *Mithuri* in less than half a decade?

From *Vanda Beheth/Pethi* (Sterility Pills) to *Mithuri* (Female Friend)

Vanda beheth/pethi was renamed *Mithuri* in 1974. This was the result of an active social marketing of contraceptives—a programme commissioned by the IPPF and conducted by Population Services International, Sri Lanka. From that time onwards, any oral contraceptive distributed through the public health sector was commonly referred to as *Mithuri*, despite a variety of different brands being

⁴¹⁹ Madihe Pagnaseeha Thero, ‘*Upath Palanaya Sinhalayan Vanda Kirimakda?*’ (Does Birth Control suggest the Extinction of Sinhala Race?), *Silumina*, 12 August 1969, p. 13.

available in the market. *Mithuri* is now marketed exclusively by the FPA of Sri Lanka.

In 1969, the concept of social marketing was applied for the first time in the world to contraceptives with the marketing of the Nirodh (meaning prevention in Sanskrit) condom in India.⁴²⁰ The second largest brand of condoms, Raja (King), was launched in Bangladesh, in 1974. Jamaica launched a social marketing programme for both condoms and oral contraceptives.⁴²¹ According to LaCheen, at least twenty-seven developing countries were implementing projects for the marketing of contraceptives by 1980.⁴²²

Influenced by the global trend of the social marketing of contraceptives, Population Services International with the support of the FPA launched the marketing of the condom brand *Preethi* (joy/happiness) in May 1973 and the oral contraceptive *Mithuri* (female friend) in December 1974.⁴²³ As a result of this programme, the Pill became widely accepted both by the Sri Lankan medical community and the general public. Eugynon ED Fe (each tablet contained 0.5mg of dl-norgestrel plus 50 µg of ethinyloestradiol) was imported from Bayer Shering

⁴²⁰ Mahinder D. Chaudhry, 'Population Policy in India,' *Population and Environment*, 11: 2 (Winter 1989), p. 104. See Anududh K. Jain, 'Marketing Research in the Nirodh Program,' *Studies in Family Planning*, 4:7 (Jul., 1973), pp. 184–90 for a detailed survey of Nirodh sales in India.

⁴²¹ Philip D. Harvey, 'The Impact of Condom Prices on Sales in Social Marketing Programs,' *Studies in Family Planning*, 25:1 (1994), p. 52.

⁴²² Cary LaCheen, 'Population Control and The Pharmaceutical Industry,' in Kathleen McDonnell (ed.), *Adverse Effects: Women and the Pharmaceutical Industry*, Ontario, Women's Educational Press, 1986, p. 114.

⁴²³ J. Davies, 'Doctors and Community Based Pill Promotion in Sri Lanka', in *IPPF Medical Bulletin*, London, IPPF, 9:3(1975), p. 1.

Pharma in Germany and re-branded *Mithuri* (female friend). The name *Mithuri*, helped to establish the Pill as the intimate, female friend of Sri Lankan women.⁴²⁴

Sri Lanka did not limit itself to a re-branding programme. An additional nation-wide mail-order distribution system was set up through which women received promotional literature by post along with an unsigned prescription for the Pill.⁴²⁵ Doctors were duly instructed to sign this pre-printed prescription that patients brought along. With the IPPF's introduction of this new marketing strategy to Sri Lanka, the clinic-oriented family planning programme shifted to retail shops. Shops were 'more convenient than clinics to the customers as they were open for longer hours, were devoid of formalities, and strict clinical routine hours of work.'⁴²⁶ According to a survey conducted by the FPA on dealers of contraceptives, *Mithuri* was sold at three types of establishments by 1981: drug stores and pharmacies, general stores and groceries, and restaurants and tea rooms.⁴²⁷ This suggests the presence of the nascent market forces which had been encroaching on Sri Lanka with the shift towards economic liberalisation from 1977. I will discuss in detail the impact of neo-liberal market forces on women's health and bodies in Sri Lanka in the next chapter. At this juncture, I will concentrate mainly on those nascent market forces that manifested themselves through the social marketing campaign of *Mithuri*.

⁴²⁴ Ibid., p. 1.

⁴²⁵ Ibid., p. 1.

⁴²⁶ De Silva (ed.), *A History of Family Planning*, p. 57.

⁴²⁷ *Survey Report on Dealers and Potential Dealers of Contraceptives*, Colombo, FPA, 1981, p. 1.

Though paper advertisements of *Mithuri* did not appear till 1976, the private practitioners and chemists advertised it through aluminium wall plaques, leaflet holders and glass-topped counter displays.⁴²⁸ This was a very effective marketing strategy and *Mithuri* became indeed a dear friend to many women and a common household name by the late 1970s.⁴²⁹ Was it the state's intention to erase the ethnic connotation attached to the Pill by cementing the relationship between women and *Mithuri*? The intimate relationship between women and their female friend *Mithuri* was further strengthened by two family planning policy decisions adopted by the government—the National Pharmaceutical Policy of Sri Lanka formulated in 1971 and the training of traditional Ayurvedic physicians to promote family planning in 1975.

The Pharmaceutical Policy of 1971 did not resist the market forces that were creeping into the health sector through *Mithuri*. The training of Ayurvedic physicians to promote family planning was an attempt to reach the grassroots. Both these policy decisions facilitated the elimination of *vanda beheth/pethi's* ethnic attire and was replaced with a modern, development attire—*Mithuri*. How did women's bodies react to this new profiling? What was really at stake in the incorporation of the two policy decisions mentioned above? Let me attempt to answer these questions through an analysis of these two policies.

⁴²⁸ J. Davies, 'Doctors and Community Based Pill Promotion', p. 2.

⁴²⁹ Newspaper advertisements and my interviews with retired school teachers, my doctor uncle, my mother, aunts, and mother-in-law.

Pharmaceutical Policy of Sri Lanka (1971)

Sri Lanka was one of the first countries in the World to come up with a National Pharmaceutical Policy, in 1971. The main aims of the policy were to reduce the number of drugs in the market, promote the prescription of generic names of drugs in both the private and the public sector, create a state purchasing agency for the whole country, expand drug production in the country and increase the provision of adequate information on drugs.⁴³⁰ How did the Pharmaceutical Policy of 1971 respond to the re-branding of Eugynon ED Fe as *Mithuri*? How was it possible for Eugynon ED Fe to shed its generic name and adorn itself in a marketable name, Mithuri? I will provide a brief history of the formulation of the National Pharmaceutical Policy in order to understand why and how Mithuri was exempted from the rules laid down by this policy in 1974.

Drug supply problems emerged during Prime Minister S.W.R.D. Bandaranaike's regime, in 1958, due to financial constraints faced by his government. As a solution to this, the Ceylon Hospitals Formulary was drawn up to decide which essential drugs should be made available in hospitals. This can be considered part of the Sinhalisation programme of the Bandaranaike regime. In 1971, during Mrs Bandaranaike's regime, this initiative was carried forward by Senaka Bibile, professor of pharmacology and dean of the Faculty of Medicine, University of Peradeniya, and Dr S.A. Wickremasinghe, medical doctor cum leftist

⁴³⁰ *Case Studies in Transfer of Technology: Pharmaceutical Policies in Sri Lanka*, Study by the UNCTAD secretariat, United Nations, 1977, p. 2. Kathleen McDonnell (1986) notes that the World Health Organisation launched its Action Program on Essential Drugs only in 1977, which designated about 200 drugs that were known to be safe, cheap, and of proven therapeutic value.

politician. They formulated the National Pharmaceutical Policy of Sri Lanka by rationalising pharmaceuticals and ensuring that 'drugs are available for those who need them in adequate quantities and at reasonable prices.'⁴³¹ The aim of the policy was to 'use limited resources to maximize drug availability by limiting drug purchases to the smallest number required for effective coverage of each category of action.'⁴³² The National Pharmaceutical Policy of Sri Lanka was used as a model for other countries to formulate their national policies on pharmaceutical use in the early 1970s.

In order to limit the number of drugs in the market, the National Formulary Committee reviewed 4,000 drugs (6,000 dosage forms) and decided to reduce the number to 2,100 drugs (3,000 dosage forms).⁴³³ Needless to say, there was much opposition to these reforms from the global pharmaceutical industry and their agents in Sri Lanka. However, in 1971, the State Pharmaceutical Corporation of Sri Lanka (SPC) was established as the state buying agency, and Professor Bibile was appointed its founder-chairman.⁴³⁴ Moreover, the National Pharmaceutical Policy stipulated that drugs could only be prescribed by their generic names, not trade names, while advertising drugs was strictly prohibited. However, *Mithuri* did not abide by either of these clauses.⁴³⁵ Davies reminds us that according to the law at the time, only licensed doctors could prescribe, and

⁴³¹ Ibid., pp. 6–8.

⁴³² Ibid., p. 8.

⁴³³ Ibid., p. 7. McDonnell (1986) points out that Bangladesh ordered off the market over 1,500 drugs that were considered hazardous or of questionable value in 1982.

⁴³⁴ *Case Studies in Transfer of Technology*, p. 8.

⁴³⁵ S.A. Wickramasinghe and S. Bibile, 'Pharmaceuticals Management in Ceylon', *British Medical Journal*, 3(1971), p. 758.

only they and licensed chemists could distribute oral contraceptives.⁴³⁶ Then why was *Mithuri* exempted from the pharmaceutical policy?

The initiative to formulate a pharmaceutical policy for Sri Lanka first came into being under the Socialist-oriented government led by Mr Bandaranaike, in 1959. The policy was adopted in 1971 under another Socialist government headed by Mrs Bandaranaike. Most importantly, the architects of the policy were members of the *Lanka Sama Samaja* Party (Sri Lanka Socialist Party), which followed a Marxist ideology. The aim of the Socialist government in the early 1970s was to provide a good healthcare system by reducing the cost of drugs without compromising their quality, in the hope of developing a nation of healthy citizens and cultivating an autonomous national identity. However, the same Socialist government did not interfere (even though the National Pharmaceutical Policy was in effect) with the FPA's social marketing of contraceptives—the *Mithuri* programme. The Pill was promoted as an over-the-counter drug in 1975. Reasons given by the Population Services International were that: 'The shops through which we reach people who want contraceptives cost us nothing. ... In contrast, clinics and health centres (aside from being relatively few in number) are very expensive to build and operate.'⁴³⁷ What were the consequences of making the Pill available over the counter? It provided women free access to the Pill without medical prescriptions or undergoing medical examinations to ascertain whether their bodies would find the Pill compatible. Unrestricted, easy

⁴³⁶ J. Davies, 'Doctors and Community Based Pill Promotion,' p. 1.

⁴³⁷ LaCheen 'Population Control and the Pharmaceutical Industry', p. 116.

accessibility to contraceptives implied that women were able to enjoy greater autonomy over their bodies. But who was holding the reins of power and autonomy in such a situation—women, the state or the market?

Emphasising the easy accessibility of *Mithuri*, a member of parliament opined at a seminar on Population and Development held in Colombo in March 1980, that women will

save the time and the embarrassment of queuing up in clinics and other places where midwives and other health officials doled out pills....They have only to go round the corner and buy their requirements from the nearest boutique.⁴³⁸

He seemed to be rejoicing in women's empowerment and their control over their bodies through *Mithuri*. However, I feel that having easy access to the Pill did not necessarily mean that women were in control of their bodies especially within the Sri Lankan context. The danger of easy accessibility was that *Mithuri* could be consumed without a medical examination regardless of its suitability for individual women. One could argue that since there were no reported deaths caused by *Mithuri* in Sri Lanka it did not pose a threat to women's health. However, in Sri Lanka, unlike in the West, there was no procedure to investigate the cause of death from any sickness, including cancer, in the 1980s. Thus, having easy access to *Mithuri without a medical examination* did not necessarily mean women's empowerment.

⁴³⁸ *Family Planning Above Party Politics: Proceedings of a Seminar on Population and Development* organised by the Ministry of Plan Implementation on 13 March 1980, Colombo, p. 12.

On the one hand, both politicians and medical doctors favoured *Mithuri* being taken off the list of prescription drugs. According to Davies, one of the doctors on the *Mithuri* programme clearly admitted his time constraints when he noted: 'I'll gladly sign the prescriptions, but you should take the Pill off prescription since none of us have time to examine the women anyway.'⁴³⁹ His attitude clearly signifies that the Pill was and continues to be considered by medical doctors, family planners and development workers a mechanism for birth control, rather than the question of an informed choice for Sri Lankan women.

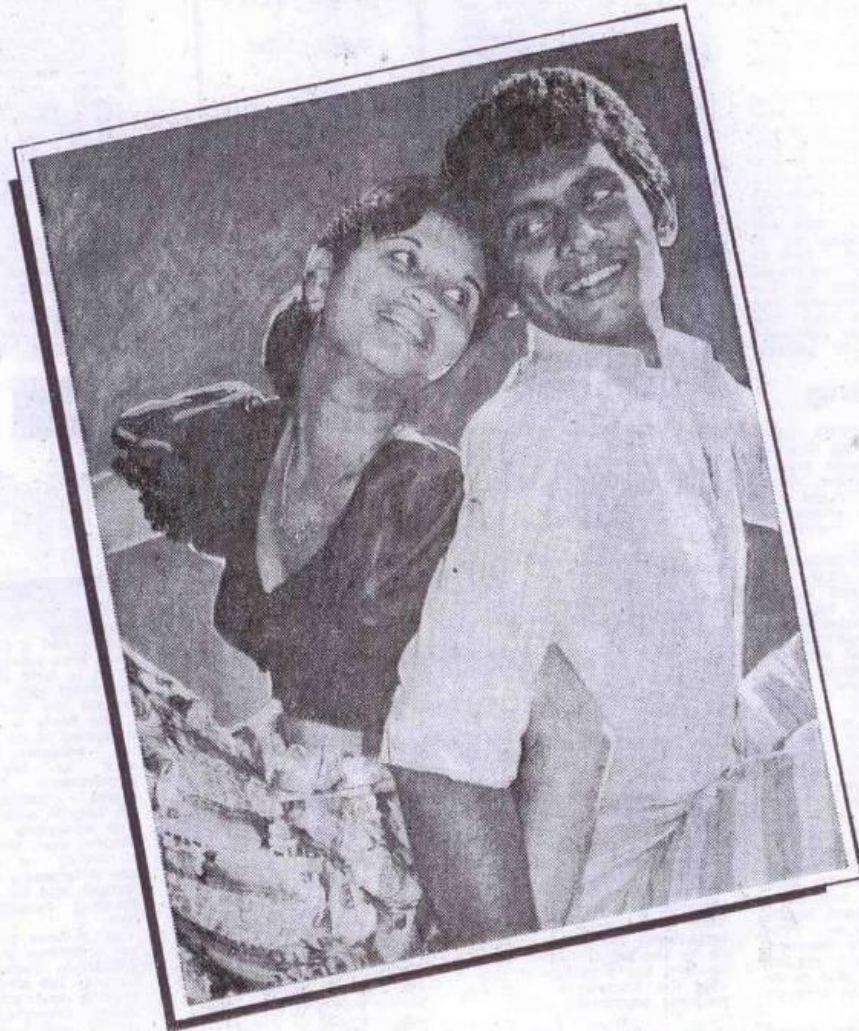
On the other hand, the state was facing a dilemma with regard to the *Mithuri* programme. The state could not challenge the *Mithuri* programme, though it did not abide by the National Pharmaceutical Policy, since it was catering to the control of the population growth rate seen as a greater national need. It was a situation where women's health and bodies were sacrificed to market forces in order to support the development dream of the state. Unfortunately, the National Pharmaceutical Policy that was designed to protect the health of the nation from market forces failed to protect the health of women from the same when they appeared in the guise of a female friend—*Mithuri*. Were Sri Lankan women empowered through the *Mithuri* programme? Given the facts above, it is evident that, it was neither women nor the state holding the reins of power but the market. The state permitted the market to 'access' its inner

⁴³⁹ J. Davies, 'Doctors and Community Based Pill Promotion', p. 2.

domain—the family—through the *Mithuri* programme. Then can we still consider Mithuri as an empowering agent for women?

The *Mithuri* programme not only made the Pill an over-the-counter drug but, reached out to villagers through advertising. After 1977, *Mithuri* advertisements conjured up an intimate, rural scenario with a happy couple in rural attire with the wording ‘because of love...’⁴⁴⁰

⁴⁴⁰ Advertisement, ‘because of love...’ *Sunday Observer*, 19 August 1979, p. 6.



because of love....

Now you are together . . . united by love . . . sharing a dream. Two happy people ready to build a home. A home filled with the musical laughter of adorable children.

Love is the basis of all these beautiful things.... your love for each other and your love for your children.

It is also love that makes you space your children. So that you have all the time and means to care for them. Today, thinking people like you use Mithuri - the simple, safe oral contraceptive.... Because of love.

Ask your Doctor for advice on Mithuri



**Mithuri the oral
contraceptive
for women.**

de Alwis

A vigorous family planning campaign was carried out by the Ministry of Plan Implementation, in the 1980s, through the introduction of new slogans such as

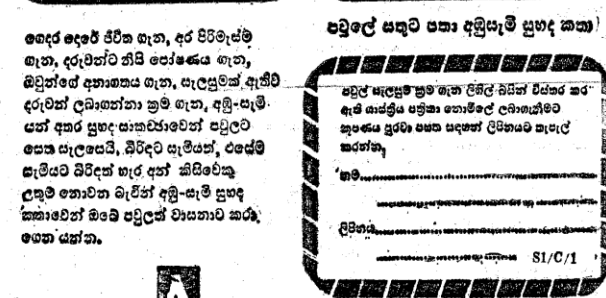
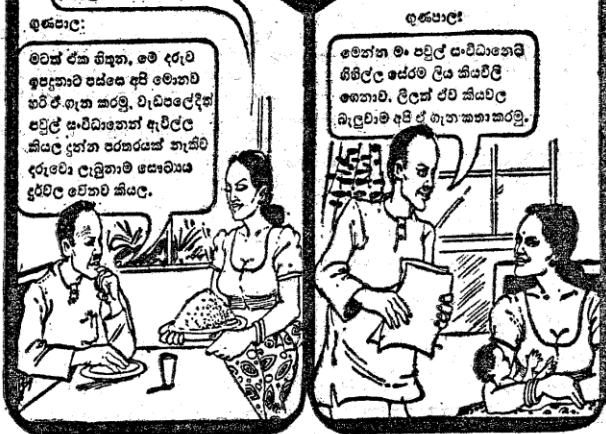
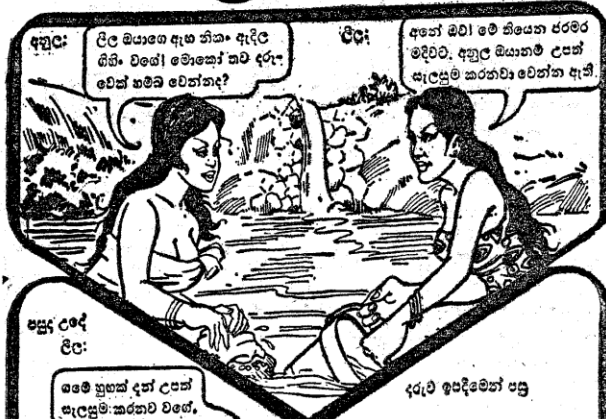
Punchi Pavula Raththaran (a small family is golden). This slogan was painted on lottery sales carts that travelled to rural areas promoting the state lottery, *Sanvardana Lottarayiya* (Development Lottery).⁴⁴¹ These lottery carts captured the development ideology of the state very succinctly; a small family (*punchi pavula*) with a mother, father and two children was considered an ideal family. By the late 1970s, FPA advertisements promoting family planning adopted rural images to reach villagers.

⁴⁴¹ Interview with the retired secretary to the Ministry of Plan Implementation on 7 August 2011 at his office in Colombo.

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The title of the advertisement 'Ganga Langa Kathawa' (Conversation by the river) shows two women exchanging information on family planning while having a

bath in the river (upper most box). One of the women who is pregnant shares with her husband the knowledge she had gleaned from her friend the next day (box on the left). Once the baby is born, the husband brings information on family planning methods obtained from the FPA and says 'let's discuss family planning once you read all this information' (box on the right). At the very bottom of the advertisement there is a statement by the FPA: 'in order to lead the family towards progress, husband and wife must discuss and plan their families.'⁴⁴² The idea of progress and development through family planning was the key message that the family planning programme promoted in the late 1970s.

In 1975, Ayurvedic physicians, for the first time, were called upon to take the Pill to the rural masses. Dr Malcom Potts, director general of the IPPF in 1974, shared the reason for this unusual move by saying that an Ayurvedic physician has 'a skill with people that the Western doctor often lacks.'⁴⁴³ The ideological change that was initiated through the social marketing programme of contraceptives was rejuvenated by incorporating Ayurvedic physicians into family planning activities.

Incorporating Ayurvedic Physicians into Family Planning Activities

The second policy decision taken by the state to cement women's relationship with *Mithuri* was to train Ayurvedic physicians in family planning activities. Dr Malcom Potts begged these traditional physicians who were first trained in family planning in 1975: 'Please help us. Please take the Pill we have invented and tell us

⁴⁴² Advertisement, 'Ganga Langa Kathawa' (Talk by the River), *Dinamina*, 13 August, 1977, p. 8.

⁴⁴³ De Silva (ed.), *A History of Family Planning*, p. 33.

how to distribute it.’⁴⁴⁴ At his request, traditional Ayurvedic physicians were mobilised to take the Pill into rural areas. How did the government manage to get one of Bandaranaike’s five forces of Sinhala nationalism to distribute the modern, Western Pill to the rural masses? More importantly, how did an Ayurvedic physician who upholds traditional culture introduce a modern, Western technological invention (once seen as an anathema, *vanda beheth/pethi*, by Sinhala nationalists) to the rural masses?

The traditional and the Western medical systems were rarely in dialogue on subjects such as family planning and contraception. Family planning was perceived as an entirely Western medical and development issue until Dr Malcom Potts called upon Ayurvedic physicians to introduce the Pill to the rural masses, at the First International Scientific Congress of the FPA held in Colombo, from 21 to 26 January 1974.⁴⁴⁵ This suggestion was reiterated in the evaluation report written by one of the doctors involved in the *Mithuri* marketing programme: ‘Why don’t you let the indigenous physicians (Ayurvedic physicians) dispense the Pill also. They are even closer to the masses than we are and have greater influence.’⁴⁴⁶

By 1974, there were around 16,000 registered Ayurvedic physicians in the country.⁴⁴⁷ Since Ayurvedic physicians seek to uphold traditional culture, they did not have a favourable attitude towards family planning as it was considered a modern, Western concept. In spite of this, the Department of Health launched a

⁴⁴⁴ Ibid., p. 33.

⁴⁴⁵ Ibid., p. 33.

⁴⁴⁶ J. Davies, ‘Doctors and Community Based Pill Promotion’, p. 2.

⁴⁴⁷ *Annual Report of the FPA 1976*, Colombo, FPA, 1977, p. 9.

training programme, funded by the IPPF through the FPA, to enrol Ayurvedic physicians to participate in the family planning effort.⁴⁴⁸ Initially, 25 Ayurvedic physicians were trained, but, by the end of 1975, 165 were engaged in promoting family planning in their areas.⁴⁴⁹ By 1977, there were 800 Ayurvedic physicians promoting family planning.⁴⁵⁰ The training of these physicians was complemented by an increase in the number of the retail outlet base of oral contraceptives, in 1978.⁴⁵¹

It was indeed a strategic move by the IPPF to use the traditional medical system to promote a modern family planning technology, because that proved to be the best way to reach the rural masses. The IPPF was able to make ideological inroads into the 'inner' domain of the nation through these Ayurvedic physicians as well as retail outlets. *Mithuri* thus became a bosom friend of Sri Lankan women with the blessings of both the Western and the traditional medical system.

Currently, the government distributes 30 micrograms of ethinyl oestradiol and 150 micrograms of levonorgestrel obtained from WHO-pre-qualified manufacturers who are on the procurement list of the UNFPA.⁴⁵² These pills are distributed free of charge or 'doled out'—as one government minister had put it—

⁴⁴⁸ Ibid., p. 9.

⁴⁴⁹ *Annual Report of the FPA 1976*, p. 18. One of the first 25 Ayurvedic physicians confided in me, that, 'the family planning training was a great opening at that time for the Ayurvedic physicians to get their lost status in society, especially among the middle class of the country.' Interview conducted on 6 April 2011 with Dr O. Jayawardene, former dean of the Institute of Indigenous Medicine, University of Colombo.

⁴⁵⁰ De Silva (ed.), *A History of Family Planning*, p. 194.

⁴⁵¹ *Annual Report of the FPA 1996/97*, Colombo, FPA, 1997, p. 33.

⁴⁵² Through my communications (email and telephone) with the consultant community physician in charge of family planning programme at the Family Health Bureau, Colombo, on 16 August 2011.

by government family health workers in accordance with the ‘free health policy’ of the government. Women who can afford to buy *Mithuri* ingest it without undergoing a medical examination to assess its suitability for their bodies. This raises the question whether *Mithuri* is truly a woman’s friend. Does it offer women an opportunity to understand and take control of their bodies, as Sanger envisioned in the 1950s?⁴⁵³

When considering the Sri Lankan situation, the liberating and emancipatory aspect of the Pill has become a double-edged sword. On the one hand, the availability and free access to the Pill gives women the possibility to control their own fertility and reproductive cycles. On the other hand, taking the Pill without medical examination means it could be detrimental to women’s health. Quoting Pappert on the adverse effects of the Pill and IUD, McDonnell reminds us that there is a possibility for the Pill to increase the risk of heart disease.⁴⁵⁴ Even though women’s bodies were liberated from reproducing because of the wide availability and easy access of the Pill, women’s health was put at risk by depriving them of medical examinations.

From medical professionals and family planners’ point of view *Mithuri* is the perfect answer to keep up replacement-level fertility already achieved in 1994, and its free availability exemplifies women’s empowerment in Sri Lanka. However, the rebranding of the Pill as *Mithuri* erased its ethnic connotation, the liberal market forces that *Mithuri* introduced jeopardised women’s health.

⁴⁵³ Watkins, *On the Pill*, p. 14.

⁴⁵⁴ McDonnell (ed.), *Adverse Effects: Women and the Pharmaceutical*, p. 4.

Concluding Thoughts

The invention of the Pill was indeed a historic moment. For medical and health professionals it was the first life-style medicine of the twentieth century. It transformed the discourse on pills in modern society by inventing a Pill for healthy women; not to treat any disorder or discomfort. For demographers, it was a pacifier to control the growing population of the Third World. For family planning activists, it sexually emancipated women. For development activists, it was a panacea for underdevelopment. For pharmaceutical companies it ensured lucrative profits. Further, it marked a moment of negotiation and bargain with different institutional and social structures and networks in order to invent, conduct human trials and introduce to the public through the Food and Drug Administration of the United States.

The history of the Pill trials and its introduction to Sri Lanka is of special significance for my thesis as it brings women's health and discourses on woman's body into a unified analytical framework. The introduction of the Pill came as a major women's health initiative in 1961, but it gained meaning through discourses on woman's body, first as *vanda beheth/pethi* in the late 1960s and later as *Mithuri* in the mid-1970s.

The medical director of the FPA of Sri Lanka, Dr Siva Chinnatamby volunteered to undertake clinical trials of the Pill, while the Boston Pill team accommodated Chinnatamby's request by changing the initial geographical settings for the Pill trials. Influenced by the planning ideology of the 1960s, she set

into motion the foremost women's health initiative of the day to plan the unplanned families of Sri Lanka. Even though Chinnatamby failed to contribute to the global Pill trials due to her inability to produce proper Pap smear slides, she definitely knotted the FPA and the government together through the Pill trials and induced the government take family planning on its agenda by 1965.

When Sinhalese Buddhist nationalists named the Pill *vanda beheth/pethi* in the late 1960s, they inserted this women's health initiative into a discourse on women's bodies. *Vanda beheth/pethi* was rebranded as *Mithuri* in 1975, through the social marketing programme of contraceptives. This shift from *vanda beheth/pethi* to *Mithuri* created easy access to the Pill since it became an over-the-counter drug. Further, this shift silenced nationalist sentiments and ethnic tensions by providing a new development outlook through *Mithuri*. The social marketing programme of contraceptives came into being with such a force that the National Pharmaceutical Policy of Sri Lanka exempted this re-branding process and enabled *Mithuri* to plan the unplanned families of Sri Lanka by taking it off the list of prescription drugs and making it widely available in retail shops. However, what does it mean to have liberal access to the Pill without any medical examination? I argue that *Mithuri* empowered women to have control over their reproductive bodies, but at the cost of their health.

As mentioned in the Introduction, my analysis of two significant women's health initiatives of independent Sri Lanka—the introduction of the Pill in 1961 and the launching of the island-wide WWC programme in 1996—marks two key

moments in my thesis. In readiness for the exploration of the second women's health initiative, WWC programme, the next chapter will provide a detailed analysis of discourses on woman's body in the 1990s, as the Sri Lankan state re-defined and mobilised women and their bodies in particular ways as a response to the economic and political turmoil it experienced.

Chapter Four

The 1990s: A Decade of Turbulence

Docile Girls, Responsible Mothers and Brave Mothers

Abstract

The Sri Lankan state re-framed and mobilised women and their bodies through ideologies and discourses of 'patriarchy' and 'motherhood' in response to the economic, political and governmental turmoil of the 1990s. This chapter retells the history of this turbulent decade to show how economic, military and political policies side-lined policies of women's health. This story is crucial to the understanding of the ideological shift in women's health—from family planning to reproductive health and rights—introduced to Sri Lanka through the island-wide Well Woman Clinic (WWC) programme in 1996.

Through my analysis of Structural Adjustment Policies (SAPs), the militarised conflict in the 1990s and through in-depth interviews with Free Trade Zone (FTZ) workers and migrant women, I show how this new veneration of womanhood and motherhood created a disconnect with the shift that the ICPD was proposing towards reproductive health and rights. It is necessary to draw a picture of the state's continuous framing of women's bodies within social reproductive roles as docile girls in FTZs, responsible mothers in the Gulf and brave mothers in a nation in turmoil where human rights were undermined, in order to understand the disconnect between the discourses on woman's body and the proposed shift in the women's health discourse. By doing so, this chapter serves as a preface to the next chapter.

Introduction

Chronologically, Chapter Four and Five are the continuation of Chapter One and Two in which I located the discourse on women's health in Sri Lanka within global population and development discourses. In the preceding chapters, I argued that due to a controlled and planned women's health programme, Sri Lanka became a 'development model' for South Asia, in the 1970s. As a result, the main focus of the women's health discourse became reproduction within a 'controlling and planning' ideology. By the 1980s, with the opening of the economy, Sri Lanka initiated dynamic development programmes, which were aimed at the careful planning of the population. As mentioned in Chapter One, Sri Lanka came under strain in the 1990s due to economic and political turmoil.⁴⁵⁵ The state re-defined and mobilised women and their bodies in particular ways responding to this turmoil. This chapter investigates how the state framings of bodies of docile girls, responsible mothers and brave mothers in the 1990s affected the discourse on women's health in Sri Lanka.

The first section in this chapter discusses the way the state has framed FTZ workers as docile and disciplined young women. The second section discusses responsible mothers in the Gulf shouldering the economic hardships of the family. The third section discusses the role of brave mothers protecting the nation-state in time of a governmental disorder. Migrant domestic labour and female headed

⁴⁵⁵ For an insightful analysis of violence in 1990s Sri Lanka, especially with regard to women, see Malathi de Alwis (ed.), *Cat's Eye: A Feminist Gaze on Current Issues*, Colombo, Social Scientists' Association, 2000. This book elaborates issues around the drafting of the Domestic Violence Bill in Sri Lanka, the debates on sexual harassment and the widely published rape cases during the 1990s.)

households created new ideas of motherhood in Sri Lanka. In the context of the militarised ethnic conflict, each faction deployed the concept of 'motherhood' in several different ways. The state's framing of these tropes of motherhood were crucial in the 1990s, because the ideology shift in women's health towards an emphasis on reproductive health and rights could not be realised. It is necessary to explain the forms of 'motherhood' that were at play in the 1990s Sri Lanka and what I mean by patriarchy, before I proceed to analyse the three figures of womanhood.

Women in the Patriarchal Welfare State

The 'ideology of motherhood' only makes sense in 1990s Sri Lanka within the broader social, cultural, economic and political landscape dominated by patriarchal norms and values. Patriarchy is a concept used in feminist, Marxist and socialist literature to analyse the principles underlying women's oppression. In feminist writing, patriarchy refers to 'male domination and to the power relationships by which men dominate women.'⁴⁵⁶ In Marxist literature, patriarchy refers to kinship systems in which men exchange women and the symbolic power held by fathers within these systems. Demographer Caldwell referred to the Middle East, North Africa and South Asia as the 'patriarchal belt' based on the relationship between fertility rates and status of women.⁴⁵⁷

⁴⁵⁶ Veronica Beechy, 'On Patriarchy', *Feminist Review*, 3:1979, p. 66.

⁴⁵⁷ John Caldwell, *Theory of Fertility Decline*, London and New York, Academic Press, 1982. Further for a conceptual analysis of patriarchy refer Delphy (1977), McDonough and Harrison

A number of Scandinavian studies have been done on the relationship between the welfare state and women/motherhood in the 1970s and 1980s, which I found useful to the analysis of patriarchy and motherhood in 1990s Sri Lanka. Leira noted that a number of feminist scholars, such as Seccombe (1974), Dalla Costa and James (1975), and Eisenstein (1979), conceive of the welfare state as 'patriarchal' and inherently oppressive because it organises social reproduction in such a way by assigning childcare and upbringing to women.⁴⁵⁸ They see it as perpetuation of men's dominance and women's subordination.⁴⁵⁹ In her analysis of women's status as citizens, clients and employees of the state, Hernes argues that the welfare state exercises some form of 'tutelage' towards women in its policies.⁴⁶⁰ Contesting this interpretation, Siim (1984) contended that the welfare state forms a partnership with women in social reproduction.⁴⁶¹ Drawing on Eisenstein's and Siim's works Leira argues that the welfare state acts both as a 'patriarch' and in 'partnership' with women and their social reproductive role.⁴⁶² When looking at the Sri Lankan welfare state, the product of colonialism, I feel it is particularly patriarchal when it comes to the provision of free education and health care.

(1978), Hartmann (1981), Young (1981), Holter (1984), Mies (1986), Hernes (1987) and Kandiyoti (1988).

⁴⁵⁸ Arnlaug Leira, *Welfare states and working mothers: The Scandinavian experience*, Cambridge: Cambridge University Press, 1992, p. 167.

⁴⁵⁹ Ibid.

⁴⁶⁰ Helga Maria Hernes, 'Women and the Welfare State: The Transition from Private to Public Dependence,' in Harriet Holter (ed.), *Patriarchy in a Welfare Society*, Oslo, Bergen, Stavanger, Tromsø, Universitetsforlaget, 1984, p. 39.

⁴⁶¹ Leira, *Welfare States and Working Mothers*, p. 168.

⁴⁶² Ibid.

What I mean by patriarchy is the autonomy, power and privilege that men enjoy over women in Sri Lankan society. This power is not limited to the family, it extends to the community, village, work place and all human relations. All Sri Lankan women are subjected to patriarchy in varying degrees depending on class and caste. However, curiously, families in Sri Lanka are, at the same time, both patriarchal and ideologically and functionally mother-centred. The mother is venerated as '*Gedara Budun*' (Buddha at home) and the father as the head of the family.⁴⁶³ Although the authority to take decisions in the family lies with the father, it is widespread practice that mother plays a significant role in father's decision. In that sense, Sri Lankan families have both patriarchal and mother-centred attributes.

The welfare state's patriarchal attitude and responsibility as the provider of free education and health services has made the Sri Lankan state acquire a form of paternal tutelage towards women. This could be seen especially regarding women's issues, such as family planning, contraception and nation building in the 1990s, which I will discuss below under the themes of docile girls in FTZs, responsible mothers in the Gulf and brave mothers of the nation. I think turbulent events in the 1990s heightened the intensity and significance of the patriarchal nature of the Sri Lankan nation-state.

⁴⁶³ When I was 8 years old in 1983, this was one of the exam questions in my environmental studies test paper in grade 2. Today 30 years later, my daughter has to learn the same thing in school for her environmental studies. This is one of the articulations of Dharmapala's project of civilising the bourgeois middle class in colonial Sri Lanka.

This chapter has three objectives. The first objective is to explain the centrality of the notion of womanhood and motherhood to the economic, military and political struggles of 1990s Sri Lanka. The second objective is to explain why ‘motherhood’ was central as a symbolic language of the state and why was it crucially invoked and literally deployed in these three turbulent arenas. Even though ‘motherhood’ was central to the way the state deployed women’s bodies in the 1990s, the same ‘motherhood’ displaced women’s health as state strategy. By providing a critical analysis of the varieties of discourses on the woman’s body and how they were deployed, the third objective of this chapter is to guide the dissertation towards the ultimate aim of placing the discourses on women’s health and women’s bodies in a unified discursive frame.

Three Figures of the Ideology of Womanhood and Motherhood

As mentioned in Chapter One, even though SAPs were introduced to Sri Lanka to further liberalise the economy, ‘women’s empowerment’ did not follow suit as expected by the proponents of the neoliberal agenda. The state made use of women’s nimble fingers, and their docile, disciplined bodies in FTZs. The state deployed the traditional gendered roles assigned to the woman’s body to support the economic development of the country during the escalating ethnic conflict of the 1990s (which I will discuss under the section of ‘brave mothers’ below).

Figure 1: Docile Girls of the Free Trade Zones

As I have mentioned in Chapter One, the first FTZ of Sri Lanka was established in Katunayake, in 1978. Many claimed that Sri Lankan women brought up in a strict patriarchal family background fitted well to the requirement of the global garment industry. To ensure the smooth supply of garments and to meet the demands of the global market, a disciplined and docile work force with 'nimble fingers' was put to work.⁴⁶⁴ Women employed in FTZs are mostly between the ages of 18 and 25 and single.⁴⁶⁵ Even though these women made and continue to make a major economic contribution to the country while working in all forms of exploitative conditions, they are neither respected in their villages nor in the new factory environment.⁴⁶⁶ The economic growth that the country acquired through the garment industry was facilitated by a liberalised market, and globalisation pushed these women into a very uncomfortable situation at the local level.

Mainstream Sri Lankan society perceives garment workers as a group of women with loose and daring character who are degrading traditional cultural values of society.⁴⁶⁷ They do not fit into the ideal image of the Sinhala Buddhist woman, mainly due to the freedom that they enjoy being away from the

⁴⁶⁴ Caitrin Lynch, *Juki Girls, Good Girls: Gender and Cultural Politics in Sri Lanka's Global Garment Industry*, Ithaca and London, Cornell University Press, 2007, p. 27.

⁴⁶⁵ Sepali Kottegoda, 'Bringing Home the Money: Migration and Poverty in Gender Politics in Sri Lanka' in Sadhna Arya and Anupama Roy (eds), *Women and Migration in Asia Volume 2: Poverty, Gender and Migration*, New Delhi/Thousand Oaks/London, Sage Publications, 2006, p. 51.

⁴⁶⁶ See Swarna Jayaweera, *The Hidden Face of Development: Women, Work and Equality in Sri Lanka*, Colombo: CENWOR, 1989, for the exploitative conditions in which the FTZ workers work and live.

⁴⁶⁷ For an insightful analysis of Katunayake FTZ workers see Sandya Hewamanne, *Stitching Identities in a Free Trade Zone: Gender and Politics in Sri Lanka*, Philadelphia, University of Pennsylvania Press, 2008 and for 200 Garment Factory Programme see Lynch, *Juki Girls, Good Girls*, 2007.

patriarchal family set up.⁴⁶⁸ The idea of unmarried girls living alone in hostels or boarding houses away from the patriarchal family structure opened the space to disrespect them as immodest, in this new city culture. They are accused of crossing the border from the domestic to the public.⁴⁶⁹

Juki is the brand name of the Japanese sewing machine imported to the garment factories of Sri Lanka. Since the Juki machine is a high speed sewing machine, garment workers undergo an on the job training to use this particular Juki machine. Thus, garment workers were stigmatised as 'Juki *kello*' (Juki girls), 'Juki *kæli*' (Juki pieces) or 'Juki *badu*' (Juki things). The terms *kæli* (pieces) and *badu* (things) carry connotations of garment workers' loose morals, their easy and licentious nature and that they can be used and thrown away like a commodity. The Katunayake FTZ was generally referred to as *sthri puraya* (the city of women), *prema kalape* (love zone) and *vesa kapalape* (whore zone) also implying garment workers' loose character.⁴⁷⁰ Lynch reminds us of the gravity of the stigma attached to these workers by quoting marriage proposal adverts in Sinhalese newspapers, which disqualify garment workers by including the phrase 'no garment girls' or

⁴⁶⁸ I will discuss the historical background of the creation of the ideal Sinhalese Buddhist woman in the next chapter.

⁴⁶⁹ Even though women also leave their parental home to go live in university hostels in pursuit of tertiary education, they are not regarded loose and daring. Like the garment factory girls, female university students, too, enjoy a particular freedom by being away from the patriarchal family set up. They are not considered loose mainly due to the high regard that Sri Lankan society places on education. The same act of leaving the parental home creates two different perceptions on these two groups of women, merely because of the difference in purpose. For an insightful analysis on the notion of sexuality among university students see Eshani Ruwanpura, 'Sex or Sensibility: The Making of chaste women and promiscuous men in a Sri Lankan University Setting,' unpublished PhD thesis, University of Edinburgh, 2011.

⁴⁷⁰ Hewamanne, *Stitching Identities in a Free Trade Zone*, p. 12.

‘no Juki girls’.⁴⁷¹ ‘Respectable’ parents did not want their sons to marry girls assumed to be licentious, despite being the ones shouldering the economic burden of the country. The same ‘respectable’ parents, however, would rejoice if they found graduate brides for their sons.

In response to the problem of the FTZ ‘Juki Girls’, President Premadasa introduced the 200 Garment Factory Programme, where factories were built in villages and not in cities.⁴⁷² Lynch recounts that the 200 Garment Factory Programme and the conflict situation in the country were neatly summed up in general usage as *gani Juki, pirimi tuwakku* (‘women work in garment factories, men work in the army’).⁴⁷³ Since the 200 Garment Factory programme did not require girls to migrate from their parental homes in search of employment, they did not have to leave the domestic sphere, these garment factories were seen as ‘good’; the girls working in these factories were good Juki girls unlike the FTZ workers of Katunayake. Quoting Premadasa on these factory openings, Lynch points out that

Premadasa argued in numerous forums – from the moment he introduced the programme (200 Garment Factory Programme) to investors – that the programme would bring discipline to the nation’s rural heartland, which recently had been the source of revolutionaries for a violent youth revolt by the JVP.⁴⁷⁴

⁴⁷¹ Lynch, *Juki Girls, Good Girls*, p. 10.

⁴⁷² The aim was to establish a garment factory in each of the 200 Assistant Government Agent (AGA) Division in the country and to create nearly 100,000 jobs.

⁴⁷³ Lynch, *Juki Girls, Good Girls*, p. 27.

⁴⁷⁴ Caitrin Lynch, ‘Economic Liberalization, Nationalism and Women’s Morality’ in Deborah Winslow and Michael Woost (eds), *Economy, Culture, and Civil War in Sri Lanka*, Bloomington and Indianapolis, Indiana University Press, 2004, p. 169. (pp. 161-191).

Clearly, the president's statement shows the government taking on the patriarchal responsibility of disciplining the youth who were engaged in a violent revolutionary struggle against the state from 1989 to 1991. Furthermore, taking a nationalist standpoint, Premadasa called his initiative 'economic development through cultural preservation,' which meant that he intended the garment workers of these 200 factories to be 'good Juki girls', unlike the Katunayake FTZ girls.⁴⁷⁵ These statements clearly manifest Premadasa's paternal responsibility not only towards the youth of Sri Lanka but also towards developing the economy of the country by guiding rural women to be economically and culturally productive. In support of this decision in 2003, six Sinhalese songs were composed and sung by renowned singers Victor Rathnayake, Deepika Priyadarshani and Rukantha Gunathilake to inspire people to praise and give due recognition to the apparel industry work force.⁴⁷⁶ Challenging the derogative term '*Juki kæli*', these songs address FTZ girls with respect by using terms such as *kumariye* (princess), *nangi* (younger sister), *diyaniya* (daughter) and *rajina* (queen). By recognising the burden that they shoulder when they take up work at a garment factory, these songs appeal not to frown at them. *Amma bandu pemmadara sammaguna piripun ema sannaliya nanga desa nobalan vaparaesakin* ('do not frown at the younger sister, her who bears mothers' love within her').⁴⁷⁷ The idea of them bearing the

⁴⁷⁵ Lynch, *Juki Girls, Good Girls*, p. 6.

⁴⁷⁶ 'Musical Tribute to the Juki girls', *Sunday Observer*, 26 October 2003. '*Numba Rajinakayeyi Sithuna*' ('You seem like a Queen') is the title of the CD. <http://www.sundayobserver.lk/2003/10/26/mag02.html> (Accessed online on 30 May 2012).

⁴⁷⁷ *Sayurin Eha* (song 'Beyond the Sea' on the '*Numba Rajinakayeyi Sithuna*' CD). <http://www.youtube.com/watch?v=btSE6GMgl-o> (Accessed on 19 July 2013).

country's burden on their shoulder, being the strength and the income generator to Mother Lanka are some of the most powerful images that these songs created. These manifestations further facilitated the state's paternal role.

As mentioned in the introductory chapter, both FTZ workers and migrant women occupied a distinct and privileged position within contemporary state policies and the social milieu of Sri Lanka.⁴⁷⁸ Both are significant for my thesis because their corporeality challenges traditional women's role within patriarchal society. By engaging in migrant employment they crossed the traditional domestic boundary and entered the public sphere. But, by working in exploitative working environments, they get trapped between enjoying their emancipation and serving the patriarchal state for economic development. I consider them a group of women marginal to the body politic of the state, but central to the national economy. Because of their centrality to the national economy, the state was more attentive towards regulating their bodies rather than caring for their health.

Considering the importance that the state places on reproduction within the women's health agenda of Sri Lanka, it is not surprising that the state had an indifferent stand on the health of these two groups of women, because they are non-procreative bodies. My in-depth interviews with these two groups of women show how the state failed to accommodate the ideological shift in women's health from controlled and planned women's health to a reproductive health and rights

⁴⁷⁸ See studies of Hewamanna, *Stitching Identities*, 2007 and Gamburd, M.R., *The Kitchen Spoon's Handle; Transnationalism and Sri Lanka's Migrant Housemaids*, New York, Cornell University Press, 2000.

agenda, because women's bodies continued to be framed within traditional contours. The state did not cater to the health needs of FTZ workers and migrant women, because, on the one hand, they are non-procreative bodies and bear no impact on the fertility rate of the country (which had reached replacement-level fertility by 1994), on the other hand, the state did not perceive women's health beyond reproduction. The state's reproductive centred women's health perception failed to accommodate the changing economic and geographic milieu which bears a direct impact on these women's lives, health and bodies.

In order to understand how these two groups of women see their bodies and health I conducted in-depth interviews with them. Having interviewed ten women from each category in order to get a snapshot of the situation, I selected five from each category to conduct unstructured in-depth interviews. I conducted these interviews (along with my archival work) from August 2009 to September 2010.

Emergency Contraceptive Pill and FTZ Workers

My in-depth interviews with FTZ workers brought the state's perception of women's bodies mobilised for economic development and women's perception of their own bodies into conversation. It was a conversation between women's bodies at a macro level (women's bodies mobilised by the state) and women's bodies at a micro level (women's understanding of their bodies). My interviews support my

claim that the state remains indifferent towards FTZ women's health since they are non-procreative bodies.

All FTZ interviewees agreed that the general perception of garment workers has improved over the years, but at the same time they were very conscious of the fact that they have a less privileged position in society despite their economic contribution to the country. Responding to my question about her perception of the body, Sita (one of the FTZ workers) summed up succinctly what others tried to explain in different ways:

We are treated as objects by men, we feel that all the time by the passing comments, jokes and looks that men give us, and also when travelling in the bus. We all want to dress up nicely, use shampoo, face wash and cream, adorn ourselves with the latest fashion jewellery, and perfumes. That does not mean that we should be treated as some kind of an object. It is indeed a pity that no man in this area would want to have an unselfish, decent romantic love like in *Gehenu Lamai* (referring to a popular teledrama based on a Sinhala novel in the 1950s) towards a garment girl. Men only get friendly with us for carnal pleasure; there is nothing more to most of the affairs that spring up here. Do you think that we like or enjoy that kind of treatment (referring to being objects of men)? No, we would love to be loved by men for what we are just like 'other' girls, but that freedom is snatched away from us by society.⁴⁷⁹

Her longing for respect reminded me of a point made by one of the former executive directors of the FPA (1975–2005), during my conversations with him about the family planning programme of Sri Lanka during his time. He said,

[t]he government had neglected the two most sexually active groups; garment workers and migrant women, within the family planning programme. I personally see this as the government taking advantage of these two groups of women in order to boost the

⁴⁷⁹ Interview with Sita (FTZ worker) on 18 September 2010 at her boarding place in Katunayake.

economy of the country at the expense of their well-being and social respect. Actually, the government has pushed them into prostitution.⁴⁸⁰

His criticism of the government's insensitivity towards the consequences that these two groups of women have to face due to their work environments, and Sita's yearning for social respect highlights two issues at hand. First, these comments point out how women are exploited in the liberal market economy. Second, they point towards the troubled position of the state operating in the liberal market economy. On the one hand, the state exploits the labour of FTZ and migrant women to develop the country's economy. On the other hand, the state remains insensitive about the negative attitudes that develop at home towards these workers for not conforming to socially accepted norms and behaviour. This indifference towards women's social respect and dignity is clearly reflected in the health care service that the government provides to these docile girls.

Due to very restrictive laws on abortion in Sri Lanka, there is no full data available. However, the FHB (Family Health Bureau) states that 'in 2008, 700 abortions were performed every day for a total of 250,000 a year. Last year (2011), this was up to a thousand a day for a total of 300,000 a year.'⁴⁸¹ Another study inquiring into the occupational status of abortion seekers testifies that garment factory workers stand out as the most represented group with requesting 33.5

⁴⁸⁰ Interview with the first executive director of the FPA (1975–2005) on 21 December 2009.

⁴⁸¹ <http://www.asianews.it/news-en/Against-abortion,-Sri-Lankan-bishops-set-day-for-unborn-children-26315.html> (Accessed on 13 November 2012).

percent of all abortions.⁴⁸² Since abortion is still illegal in Sri Lanka, these abortions are performed in inappropriate medical settings hazardous to health. In 2008, 11.7 percent of maternal deaths were reported due to septic abortions.⁴⁸³ According to Savithri Gunasekere, eminent lawyer and human rights activist, despite many attempts since 1995 to broaden the exceptions and permit abortion ‘in the event of rape, incest or grave foetal defects,’ a permissive law did not materialise due to pressure from religious groups.⁴⁸⁴ Given that 33.5 percent of abortions are done by FTZ women (garment factory workers), I asked Rekha (FTZ worker) about the service they receive from public health midwives (PHM) in the area. Her prompt answer was, ‘we have midwives visiting pregnant women in the area.’ Then I asked about other services such as family planning and Well Woman Clinic tests that PHMs are expected to provide. Her answer was that

midwives *only* visit pregnant women and they do not work on weekends, so it is very difficult for us to get their services. Whatever the knowledge we have on reproductive health, family planning and contraception is due to NGO workshops conducted by *Dabindu* or the FPA. Apart from that of course we (making a gesture towards her work colleagues) share what we know.⁴⁸⁵

⁴⁸² L. Senananyake, S. Wilathgamuwa and K. Jayasinghe, *Reducing the burden of Unsafe Abortion in Sri Lanka; A Situation Analysis and Plan of Action*, Colombo, FPA, 2009, p. 13.

⁴⁸³ http://medistatsrilanka.org/yahoo_site_admin/assets/docs/abortion_economic_final_report.239205908.pdf (Accessed on 3 November 2012).

⁴⁸⁴ Savithri Goonesekere, ‘Gender, Equality and the Empowerment of Women in Sri Lanka’ in Bradman Weerakoon (ed.), *ICPD – ‘15 Years on’ Sri Lanka; A Review of Progress*, Colombo, FPA, 2009, p. 30.

⁴⁸⁵ Interview with Rekha (FTZ worker) on 25 September 2010 at her boarding place in Katunayake. *Dabindu* Collective Sri Lanka is a women’s organisation established in 1984 in Katunayake that provides legal aid and counselling for women workers. It considers health as one of their priorities.

As I have mentioned in Chapter Two, traditionally women are only expected to be sexually active within marriage (although this perception is rapidly changing at present), thus the government family planning programme caters only to married couples.⁴⁸⁶

Despite the evidence of abortion rates, largely unmarried cohorts of women FTZ workers do not come under the purview of the government family planning programme. Even though the former executive director of the FPA spoke of the government family planning programme in an accusing tone for being insensitive towards FTZ workers, the FPA, an NGO, reached the FTZs with the introduction of the Postinor 2, the emergency contraceptive pill, only in 1997. Educational programmes on reproductive health were conducted for the first time by the FPA in FTZs under the emergency contraceptive pill project. As reported by the FPA, 'these programmes (meaning educational programmes on reproductive health) were also aimed at promoting the use of the Emergency Contraceptive Pill to prevent unwanted pregnancies.'⁴⁸⁷ I see a troubled connection between the educational programmes on reproductive health and the Postinor 2 project. Why did the FPA not conduct educational programmes on reproductive health to FTZ workers before the Postinor 2 project? What is the relationship between the Postinor 2 project and the FPA conducting reproductive health programmes to the FTZ workers?

⁴⁸⁶ Eshani Ruwanpura, (2011) shows us otherwise in her unpublished PhD thesis. I will be discussing in detail when a woman becomes legible to the government health sector in the following chapter.

⁴⁸⁷ *Annual Report of the FPA, 1998–99*, Colombo, FPA, 1999, p. 3.

As was succinctly put down in the FPA's *Annual Report of 1998–99*, the FPA was not concerned about the health of FTZ workers, only about whether their reproductive bodies were producing 'unwanted' pregnancies that would blemish the women's health success story of South Asia. Rejoicing in the increasing sales of Postinor 2, the medical director of the FPA, said to the *Sunday Times* (Sri Lanka) in 2003 that 'Five years ago we sold 500 packets (Postinor 2) a month. Today we are selling 26,000 packets a month.'⁴⁸⁸ This statement shows that there is hardly any difference between the state's women's health agenda and the FPA's agenda; both institutions are focused on keeping fertility rates under control rather than having a broader outlook towards women's health. In other words, the women's health programme of Sri Lanka is focussed on silencing the bodies of the FTZ workers rather than providing them with safe health care facilities.

When considering all these incidents and points (former executive director's comment on the government's attitude towards women's health, the high abortion rate among FTZ workers, FTZ workers' difficulty in accessing public health services and the FPA reaching FTZ workers only through the emergency contraceptive pill project), I find that these all add up to one particularly intriguing aspect of discourse on woman's body in 1990s Sri Lanka. That is, it was not women's health or welfare that the national women's health programme was concerned about, but to keep women's reproductive bodies muted by using traditional markers. The state demands a disciplined docile body (within the

⁴⁸⁸ P. K. Balachandran, 'Anti-abortion law spurs abortions', *The Sunday Times* (e edition) 9 November 2009, <http://www.sundaytimes.lk/031109/plus/4.htm> (Accessed on 5 November 2012).

traditional framework) from women to contribute to the GDP of the country, but disregards the direct impact of economic transformation and the new work environment on their lives, health and bodies. In other words, the primary premise of the woman's body discourse did not change according to the changing economic milieu (second phase of SAPs), women continued to be seen as "reproducers, nurturers, disseminators of tradition, culture, community and nation".⁴⁸⁹ Because of the state's reproductive centred perception on women's health and bodies, the state failed in its remit to look after the well-being of FTZ workers and their disciplined, docile bodies despite its long-standing welfare policy on public health care.

The other category of women who have crossed the boundary from the private to the public sphere through the neo-liberal economy is the female migrant workers who I have identified as the second figure of womanhood in my thesis. Their bodies are framed by the state as responsible mothers in the Gulf.

Figure 2: Responsible Mothers in the Gulf

Just as women's labour contributed to the export income through the garment industry, women's labour constituted the largest portion of Sri Lanka's foreign exchange. Beginning with the 1970s, many South and Southeast Asian countries began sending large numbers of their citizens to work in Gulf countries on short-term contracts. In Sri Lanka, the majority of these were female domestic workers.

⁴⁸⁹ Malathi de Alwis, 'The Changing Role of Women in Sri Lankan Society' in *Social Research*, 69:3 (Fall 2002), p. 675.

In 2008, the annual outflow of workers from Sri Lanka was around 200,000. Of this sixty-six percent were female domestic workers.⁴⁹⁰ From 1999 to 2004, Sri Lanka's female migrant workers had earned Rs 478 billion (GBP 2.6 billion).⁴⁹¹ Their earnings have counted as the second highest source of foreign exchange for the country for more than two decades.⁴⁹² Mainly women from rural areas and from among the urban poor are recruited as housemaids by the government. Recruiting agencies claimed that taking up housemaids' work in the Gulf meant simply a transfer of labour from the traditional setting to a new location. Women were expected to perform the same roles, which included cooking, cleaning, nursing, caring for children, the elderly and the sick.

Even though they stepped out of the traditional place designated to women, the state re-framed those taking part in their new venture as responsible mothers who shoulder the economic hardships of the family. In other words, the state mobilised migrant women's labour by justifying their move out from home reframing them as responsible mothers. However, scholars have questioned the capacity of these women to fulfil their social reproductive role through migration.⁴⁹³

⁴⁹⁰ Annual Statistical Report of Foreign Employment 2008, Battaramulla, Sri Lanka Bureau of Foreign Employment, 2009, p. i. Also can be accessed in, <http://www.slbfelk/downloads/Annual%20Statistical%20Report%202008%20-%20SLBFE.pdf> (Accessed on 25 March 2012).

⁴⁹¹ Selvy Thiruchandran, 'Intersection of Labour Power, Female Sexuality and Notions of Nation State: The Cumulative Oppressive Process. The Case of Sri Lankan Migrant Housemaids,' in *Nivedini – Journal of Gender Studies*, Vol. 11 (July/Aug 2004), p. 76–77.

⁴⁹² Kottegoda, 'Bringing Home the Money', p. 49.

⁴⁹³ See Kottegoda, 'Bringing Home the Money,' p. 60–63 for an analysis of the issues faced by migrant workers such as change in the domestic power structure and family catastrophes of eloping

Unlike FTZ workers, a large proportion of female migrant workers are married women, often with children. Scholars such as Kottegoda have shown that their earning capacity and exposure in the Gulf challenges the patriarchal power structure of the household.⁴⁹⁴ Migrant women become the breadwinners of the family, and their childcare duties are taken over by the husband and extended family members. The state framed this challenge to the patriarchal family order in such a way as to appeal to maternal qualities of labour, emphasising how women sacrifice the comforts of their home to provide a better future for their family by labouring in the Gulf.⁴⁹⁵ This is well articulated by both Devi and Sumana (migrant workers). Devi, 34 years old, married, living in a rented room (not a house) with her 5 year old daughter and unemployed husband, said,

[m]y only consolation is that my mother and husband looked after my daughter. You know no miss (referring to me), now-a-days you cannot keep the daughter in the father's care (implying cases of incest). I'm glad that I can rely on my husband for that, even though he is unemployed, he is a good man. I think now-a-days it is men who have to trust (*vishvasa karanna*) their (housemaid) wives, not the other way round.⁴⁹⁶

children, incest, child abuse by extended family members and extramarital relationships of husbands.

⁴⁹⁴ See Sepali Kottegoda, *Negotiating Household Politics: Women's Strategies in Urban Sri Lanka*, Colombo: SSA, 2004.

⁴⁹⁵ My frequent visits to Sri Lanka during the PhD research (2009–12) gave me the opportunity to chat with migrant women on the flight to and from Sri Lanka to the Middle East. It was apparent from these conversations that these women internalised the sacrificing mother ideology to a great extent.

⁴⁹⁶ Interview with Devi (migrant worker), 1 April 2010 at her house in Rajagiriya.

Unlike the docile girls of the FTZs, migrant women projected a strong sense of autonomy in their personalities. Sumana, a migrant worker aged 42, told me that she still spansks her sixteen year old son if he is caught doing any mischief.

I am the mother and I earn a lot to give him a good future. So I will not tolerate any misconduct from him. (By misconduct she means not attending school and tuition classes and associating with bad company). He is my only child and son, taken care of by my mother and sister. I send enough money for his expenses. So he only has to study well. You know miss (addressing me), I saved money and bought him a computer recently, because all I ask from him is to have a good education. And I believe that is all what we can do for our children, don't you think?⁴⁹⁷

Even though Sumana's husband is working as an informal labourer, she spoke very little about him. The rest of the conversation was all about how she fulfils her maternal obligations. Devi's husband is unemployed and he takes care of their daughter. In both these households women became the breadwinners, and, in a sense, the husbands had switched roles with the wives. When she said 'husbands have to trust their wives,' Devi emphasised that, by switching roles, new power relations develop in the household. Women exert autonomy in their own ways within the household as they perform the role of the responsible mother towards their children. Through the state's framing of the shifting role as responsible motherhood and the way women perform this role brings a new balance to the traditional patriarchal family.

When I inquired about migrant workers' knowledge on reproductive health, Sumana's immediate response was, 'unlike those days when we first went

⁴⁹⁷ Interview with Sumana (migrant worker), 10 December 2010 at my house in Kotte.

to the Middle East, now-a-days women are given a training (language, handling of domestic appliances and health) from the Foreign Employment Bureau.⁴⁹⁸ To my question on her experience with sexual harassment on the job, she said,

this job is not for the innocent and naïve kind, then you are sure to get exploited sexually or otherwise. Personally I have never experienced any sort of exploitative treatment, I have worked in three households during the past twelve years and all treated me very well and I was ever so faithful to them. I know a woman, a friend of mine who was sexually harassed by the master of the house and we (friends) got together and found her another house through our contacts. She is from Madevachchiya (remote village in Central Province of Sri Lanka) not like us brought up in town.⁴⁹⁹

According to Sumana, women should be strong to take up migrant work in the Gulf. By being strong, Sumana refers to women's ability to make their own decisions. When women start making decisions, it affects patriarchal family relations, because traditionally decisions are taken by the male/father in the family, not by the female/mother. By being strong women, migrant workers are able to work in the Gulf retaining respect, but the same strength in their character will disturb the power relations within the family. The ideology of being good and strong mothers to their families came up very frequently during my interviews with migrant women.

The maternal responsibility emphasised both by the state and the women themselves suggest that these women form a new category as mothers without sexual desire. Leaving their home for work is accepted as long as they abide by

⁴⁹⁸ Ibid. See <http://www.slbfe.lk/article.php?article=38> for the training provided by the Foreign Employment Bureau of Sri Lanka for the migrant women. (Accessed on 4 November 2012).

⁴⁹⁹ Interview with Sumana (migrant worker), 10 Dec. 2010 at my place in Kotte.

their domestic duty towards uplifting the family. Mothers are considered a group of asexual people with child rearing responsibilities; within that nurturing and caring framework their sexual desires are often side-lined through the veneration of motherhood. Their sexuality is muted and they are bestowed with a social responsibility to uplift the family. Analysing the SAP development programmes in the late 1980s, Jayaweera points out that by promoting home economics and gender appropriate jobs for women, development planners and administrators at the decision-making level inadvertently promoted the 'housewifisation' of women.⁵⁰⁰ Migrant domestic labour is indeed seen as a gender appropriate job for women. I see the concept of housewifisation not only through the job that they perform, but also through how the state perceives their bodies. Due to the responsibilities in the household and social reproduction that women are bestowed with, the state could not perceive their bodies beyond reproduction. Because of their asexual bodies, responsible motherhood and housewifisation they do not pose a threat to the fertility rates of the country, which allows the state to turn a blind eye to their health beyond reproduction.

Apart from the indifference towards the health of FTZ workers and migrant women 'beyond reproduction' in the 1990s, the state was also preoccupied with other things such as the ethnic conflict and the JVP uprising. These issues demanded the state to reframe women's bodies further within traditional contours for nationalistic purposes. The state did not have adequate time and space to

⁵⁰⁰ Swarna Jayaweera, *The Hidden Face of Development: Women, Work and Equality in Sri Lanka*, Colombo, CENWOR, 1989, p. 12.

smoothen the rough edges of the traditional discourse on women's bodies according to the changing economic milieu. This was because the conflict situation in the 1990s, threatening the Sinhalese Buddhist nation, demanded the woman's body discourse to remain within the traditional framework.

In the midst of the militarisation of conflict, the state bestowed mothers with a national role as the brave mothers of war heroes, encouraging women to enlist their sons to the national cause. The opposition also mobilised the concept of motherhood to pressurise the government about its brutal retribution visited on the population in the wake of the JVP uprising. Both these forms of motherhood are based on Sinhala nationalist sentiments. Parallel to concepts of Sinhala motherhood, the Liberation of Tamil Tigers of Eelam (LTTE) cast mothers as warrior mothers of the Tamil Eelam.

Figure 3: Motherhood during the Militarisation of Conflict in the 1990s

President Jayawardene's second term was convulsed by two conflicts. The first began with the Tamil separatist group, the LTTE, in the north and east of Sri Lanka in 1983.⁵⁰¹ In 1989, another conflict began with the youth group JVP in the south of Sri Lanka.

⁵⁰¹ Since the 1950s, the Sri Lankan state has been pursuing a set of policies discriminatory against Tamils. These policies exacerbated ethnic tensions in the country for decades. In 1983, these tensions escalated into a full blown ethnic war. See A.J. Wilson, *The Break-Up of Sri Lanka: The Sinhalese – Tamil Conflict*, London, Orient Longman Limited, 1988; Spencer, Jonathan (ed.), *Sri Lanka: History and the Roots of Conflict*, London & New York: Routledge, 1990; de Silva, Kingsley, *Reaping the Whirlwind: Ethnic Conflict, Ethnic Politics in Sri Lanka*, New Delhi: Penguin 1998; Wilson, Alfred Jeyaratnam, *Sri Lankan Tamil Nationalism: Its Origins and Developments in the 19th and 20th Centuries*, London: Hurst, 2000; Winslow, Deborah & Michael D. Woost, (eds),

The ethnic flare up in 1983 was a great impediment to Sri Lanka's open economy. Foreign investment and foreign assistance were abruptly stopped. Instead, investors moved to Bangladesh and Pakistan, with their economies opening up in 1987 and 1988 respectively.⁵⁰² Sri Lanka's growth rate declined to 3.7 percent during the period of 1983–89.⁵⁰³ Economists have seen this catastrophe in the mid-1980s as a 'missed opportunity' for the country to become the first developed nation in South Asia.⁵⁰⁴ The shift in economic priorities due to the ethnic conflict was termed by one scholar as switching from 'welfare' to 'warfare'.⁵⁰⁵

Apart from the ethnic conflict, the second JVP uprising of 1987–90 also further deteriorated the economy and the stability of the government.⁵⁰⁶ Although the JVP had existed and engaged in periodic struggles with the government as a political party since 1971 it was not banned until 1983. This led to another protracted armed struggle with the government.

Economy, Culture, and Civil War in Sri Lanka, Bloomington, Indiana University Press, 2004; Karthigesu Sivathamby, *The Sri Lankan Ethnic Crisis – A Tamil Perspective*, Marga Monograph Series on Ethnic Reconciliation, No. 25, Colombo, Marga Institute, 2004; Karthigesu Sivathamby, 'The Sri Lankan Tamil Question Socio-Economic and Ideological Issues,' in *Security Dialogue*, October 1987, 18 (4); and Jayadeva Uyangoda, *Ethnic Conflict in Sri Lanka: Changing Dynamics*, Policy Studies 32, East-West, Centre, Washington, 2007 for a critical analysis of the ethnic conflict that lasted twenty six years (1983–2009).

⁵⁰² Kelegama, *Development Under Stress*, p. 68.

⁵⁰³ Ibid., p. 54.

⁵⁰⁴ Ibid., p. 68.

⁵⁰⁵ Ibid., p. 59.

⁵⁰⁶ Rohana Wijeweera was a medical student studying at Lumumba University in Moscow when he established the JVP in 1965. Wijeweera was a great supporter of the Chinese Communist party in Lumumba University at that time. The JVP did not have faith in traditional left parties of Sri Lanka, since they were set up by educated bourgeoisie who gained their wealth by servicing the imperial economy during the colonial period.

According to a renowned anthropologist, the political violence and terror in southern Sri Lanka between 1988 and 1991 was unprecedented in scale when compared to the scale of the ethnic conflict in the north of Sri Lanka.⁵⁰⁷ It was popularly known as *bheeshana samaya* (reign of terror). The intensity of the period can be seen from the widespread use of terms such as *athurudahanwoowo* (the disappeared), *wadhakagaraya* (torture chamber) and *issuwa* (kidnapped) which entered the popular vocabulary.⁵⁰⁸ Paying attention to the overall structure and vocabulary of violence, Perera adopts Taussig's term of 'culture of terror' to describe the political situation of southern Sri Lanka during the early 1990s.⁵⁰⁹

It was indeed a reign of terror as thousands had 'disappeared' as a result of the brutal violence of the JVP and the retribution meted out by the UNP government of President Premadasa. State paramilitary forces called Black Cats and *Kola Koti* (Green Tigers) worked towards eliminating the JVP.⁵¹⁰ Both the JVP and the state committed human rights violations. Renowned political scientists Uyangoda and Samaranayake point out a clear ideological shift between the 1971 and 1987 JVP uprisings: from a 'revolution through class struggle to liberation

⁵⁰⁷ Sasanka Perera, *Stories of Survivors: Socio-Political Contexts of Female Headed Households in Post-Terror Southern Sri Lanka (Volume 1)*, Colombo, Women's Education and Research Centre, 1999, p. 19.

⁵⁰⁸ Ibid., p. 19.

⁵⁰⁹ Ibid., p. 19. By merely distributing a leaflet the JVP made schools, offices and hospitals shut down and brought the national transport system to a complete halt. All the schools in the country were closed for three months (from September–December 1989). A number of academics, politicians, Buddhist monks, student political leaders, medical doctors, journalists and television presenters were abducted and assassinated by the JVP during this period. These abductions and assassinations were carried out by the *Deshapremi Janatha Vyaparaya* (DJV – 'Patriotic People's Movement') the armed wing of the JVP.

⁵¹⁰ De Mel, *Women and The Nation's Narrative*, p. 242.

through patriotic struggle.⁵¹¹ The state countered this patriotic struggle by adopting the similarly patriotic strategy of valorising motherhood. In the beginning of the 1990s, Sri Lanka was almost in a state of anarchy. The state was losing the battle on both ends (in the ethnic conflict in the north and east and in the JVP uprising in the south). Finally, in late 1989, Premadasa crushed the JVP with a counterinsurgency war by killing nearly 40,000–50,000 youth who believed in JVP ideology.⁵¹² After crushing the JVP uprising, Premadasa established 200 garment factories taking a paternal responsibility towards the nation (as mentioned above) in each of the 200 Assistant Government Agent (AGA) Divisions of the country with the aim of creating nearly 100,000 jobs.

All three parties involved in these conflicts, namely the state (UNP regime), the LTTE and the JVP, mobilised motherhood in various ways to achieve their political ends.⁵¹³ The Sinhalese Buddhist state and the LTTE mobilised mothers rhetorically as nurturers, guardians and brave warriors of the nation who

⁵¹¹ Jani de Silva, 'Praxis, Language and Silences: The July 1987 Uprising of the JVP in Sri Lanka' in Michael Roberts (ed.), *Sri Lanka Collective Identities Revisited Vol. II*, Colombo, Marga Institute, 1998, p. 164.

⁵¹² According to Alles (1990) on 12 of November 1989 the government managed to arrest the JVP leader (Rohana Wijeweera) who was killed in the process, although the murderers' identity is disputed. See A.C.Alles, *The JVP 1969–1989*, Colombo, Lake House Investments Ltd, 1990, for more details of the JVP uprising in Sri Lanka.

⁵¹³ The JVP had a female wing in the organisation from the beginning in the late 1960s, but the women's front of the LTTE was formed only in 1986. When women were deployed in the struggle the state army also reacted accordingly. The Sri Lanka Army Women's corps was formed in 1979 with six cadets. Today there are seven units. All these three armed forces mobilised the rhetoric of motherhood to achieve their own political ends.

Also see the link, <http://lankapuvath.lk/index.php/home/hot-stories/video-story/13180-first-women-soldier-to-sacrifice-her-life-for-the-country-> (Accessed on the 23rd March 2012).

served to produce brave sons to protect the motherland.⁵¹⁴ Maunaguru reminds us that the LTTE appealed to women to join the *Eelam* (homeland) struggle from 1984 as it would 'prove the revolutionary potentialities of Tamil women.'⁵¹⁵ The women's front of the LTTE was formed with the enlisting of women cadre in 1986 and they were named *Sutantira Paravaikkal* (Birds of Freedom).⁵¹⁶ Since this chapter is about the way the state framed womanhood and motherhood I will be specifically looking into the two types of Sinhalese Buddhist motherhood espoused by the state (UNP) and the Sri Lanka Freedom Party (SLFP) in opposition. Prior to that I think it will be useful to the subject to provide a brief background of state policies directed towards women.

State Policies on Women

Even though the FPA was established in 1953 and the FHB in 1968, in the aim of keeping population under control there was no specific policy directed towards women till the UN declared 1975–85 as the decade of women. Studying the state's interest in women's issues, Thiruchandran notes that there seemed no necessity for gender specific legislation as women enjoyed an empowered position in the

⁵¹⁴ *Vihara Maha Devi* in Sinhala literature and *Kannada* in Tamil literature are such warrior women.

⁵¹⁵ *Thalir*, Issue 21 (1984), p. 31, quoted in Sitralega Maunaguru, 'Gendering Tamil Nationalism: The Construction of 'Woman' in Projects of Protest and Control,' in Jeganathan and Ismail (eds), *Unmaking the Nation: The Politics of Identity and History in Modern Sri Lanka*, Colombo, Social Scientists' Association, 1995, p. 163.

⁵¹⁶ Selvy Thiruchandran, *The Other Victims of War: Emergence of Female Headed Households in Eastern Sri Lanka* (Volume II), Colombo, Women's Education and Research Centre, 1999, p. xv, and Catherine Brun, 'Birds of Freedom; young People, the LTTE, and Representations of Gender, Nationalism and Governance in Northern Sri Lanka,' in *Critical Asian Studies*, 40:3 (2008), p. 408, (pp. 399–422). According to Peter Schalk the first Tamil female fighters were trained in India in 1982. <http://sar.sagepub.com/content/14/2/163.full.pdf> (Accessed on 26 June 2011).

Buddhist tradition, due to un-gendered state policies on adult suffrage (universal adult suffrage was granted in 1931) and education (granted free education for both girls and boys in 1948) in Ceylon.⁵¹⁷ These achievements were celebrated both by policy makers and academics to generate an image of Sri Lanka as a template for other countries in the region. However, the state did not consider discrimination in wage structure, property relations, divorce, abortion and rape laws as important areas to be reviewed and revised. In response to the pressure exerted by UN donor agencies, the Women's Bureau and the Ministry for Women's Affairs were established in the 1980s.

Despite setting up institutions and adopting an open economic policy in 1977, policies on women were still confined to traditional contours espoused by Dharmapala during the nationalist struggles of colonial Ceylon. The state could not address gender specific issues even in the 1990s (as mentioned above), as the state was under attack from two sides by the LTTE and the JVP. De Mel notes that despite the publishing of the Women's Charter in 1993, women's groups had to keep the issues of 'domestic violence, sexual harassment, equal opportunities, abortion, women's access to safe contraception and informed choice about contraceptive methods, women's reproductive health, the image of women in the media, etc.,' on hold due to the socio-political crisis in the country.⁵¹⁸ In fact, motherhood became an extremely important trope in the nation building project

⁵¹⁷ Selvy Thiruchandran, *The Politics of Gender and Women's Agency in Post-Colonial Sri Lanka*, Colombo, Women's Education and Research Centre, 1997, p. 9.

⁵¹⁸ De Mel, *Women and The Nation's Narrative*, p. 235.

in 1990s Sri Lanka. With the militarisation of conflict, the state expanded the scope of mothers' responsibility from the family towards the nation especially through the *Seva Vanitha* Movement (SVM). The literal meaning of *Seva Vanitha* is a ladies movement to serve (*Seva* = Service and *Vanitha* = Women in Sinhala). The *Seva Vanitha* Movement was founded in June 1983 by Mrs Elena Jayawardena, wife of the then President J.R. Jayawardena. As a rule, the president's wife becomes automatically the head of the SVM. Though a self-proclaimed non-political national movement, it is funded by the President's Fund. Its membership comprises of the wives of all government officials from the grassroots level to that of the ministries.⁵¹⁹

Tropes of Motherhood

Motherhood became an important trope during ethnic conflict in Sri Lanka which lasted twenty six years (1983–2009). During the 1980s and 1990s, three groups of mothers organised active protest campaigns against the injustice, terror and violence of the state.

The Northern Mothers' Front

The first initiative to mobilise mothers for a political cause came in 1983 in protest of the state's tyrannical act of repression. In the north, the state arrested several

⁵¹⁹ See Malathi de Alwis, 'Gender, Politics and the 'Respectable Lady,' in Pradeep Jeganathan and Qadri Ismail (eds), *Unmaking the Nation: The Politics of Identity and History in Modern Sri Lanka*, Colombo, SSA, 1995, pp. 137–157.

Tamil boys suspected of 'terrorist activities'. Some were killed while others were tortured. Thiruchandran notes that ordinary women became radically politicised and joined the Mothers' Front upon hearing and seeing the killings and torture carried out by the state.⁵²⁰ The Northern Mothers' Front organised a march in June 1984 demanding the government agent of Jaffna to release their sons.⁵²¹ Nearly 10,000 women participated in this march.⁵²² Again, on 24 August 1984, over five hundred women staged a demonstration against the alleged detention of youth by state security forces.⁵²³ Even though these protest marches were not very successful, Thiruchandran sees this act of political protest by women as a moment of failed patriarchy, from which the Mothers' Front emerged as a form of contingent politics.⁵²⁴

However, due to the prevailing ethnic tension, the Northern Mothers' Front could not form links with the south to seek a peaceful solution to the ethnic conflict, thus it voluntarily disbanded in 1986 without submitting its cause to the LTTE who tried to use it for its own political ends.⁵²⁵

⁵²⁰ Selvy Thiruchandran, *The Politics of Gender and Women's Agency in Post-Colonial Sri Lanka*, Colombo, Women's Education and Research Centre, 1997, p. 41.

⁵²¹ Ibid., p. 42.

⁵²² Ibid.

⁵²³ 'Demo by Women in Jaffna,' *Daily News*, 25 August 1984, p. 1. Minister of National Security reported to *Daily News* that by 29 August 1984 only 124 were held out of the 500 suspects detained at Boosa Army camp.

⁵²⁴ Selvy Thiruchandran, *The Politics of Gender and Women's Agency in Post-Colonial Sri Lanka*, Colombo, Women's Education and Research Centre, 1997, p. 43.

⁵²⁵ Maunaguru, 'Gendering Tamil Nationalism, p. 168 and Thiruchandran, *The Politics of Gender and Women's Agency*, p. 44.

The Southern Mothers' Front

In her message to the media on International Women's Day in 1990, the president's wife and president of the *Seva Vanitha* Movement Mrs Hema Premadasa emphasised woman's contribution to the family as care givers, nurturers and moral upholders. She extolled the 'patriotic endeavors of Vihara Maha Devi which resulted in the liberation of foreign domination,' as one of the highest achievements of women, which extended from family to the nation.⁵²⁶ The president's address at the International Women's Day meeting in Kandy also reiterated these ideas. He stressed the role of women in providing health care and nutrition to the family by taking Vihara Maha Devi as an example. 'History records the great effort made by Vihara Maha Devi to bring up her two sons as healthy and strong youngsters. It is said that at the age of 14 Prince Gemunu was the equal of any warrior in the King's Army.'⁵²⁷ Supporting these claims, Mrs Premadasa unveiled the statue of Vihara Maha Devi in Kelaniya soon after the International Women's Day celebrations on 18 March 1990.⁵²⁸ From these actions it is clear that the state moulded women's role according to the characteristics of the legendary Sinhalese heroine queen Vihara Maha Devi. De Alwis in her insightful analysis on Sinhala nationalism shows how, during the 1990s, the state deployed Queen Vihara Maha Devi's famed patriotism, bravery and intelligence to

⁵²⁶ 'No Strong Society without Women', *The Island* (International Women's Day Supplement), 8 Mar. 1990.

⁵²⁷ 'Govt. has given women their due place in many respects – President', *The Island*, 12 March 1990, p. 1–2.

⁵²⁸ 'Vihara Maha Devi's life – a classic example to all women', *The Island*, 19 March 1990, p. 3.

give credence to women's role as reproducers of the nation and motherland.⁵²⁹ Quoting speeches of President Premadasa and other prominent ministers of the 1990s, she shows how the state used the example of Queen Vihara Maha Devi's patriotism (even though she adopted violent means departing from the feminine quality of peacefulness) to create an ideology of brave motherhood, claiming it has always been part of Sinhala 'history', 'culture' and 'tradition'.⁵³⁰ The idea of women as protectors of the nation keeps Dharmapala's notions of women's social reproductive responsibilities and duties towards the nation ever so alive.⁵³¹

Addressing this crisis situation the Mothers and Daughters of Lanka (MDL), a civil society organisation, was formed in 1989, which comprised women from diverse ethnic communities and religious backgrounds. Their appeal to 'stop killing' was not directed at any one particular political group but to all three parties (the state, the JVP and the LTTE).⁵³²

While the MDL did not have any affiliation to a political party, Mothers' Front was established under the auspices of the opposition (SLFP) in 1990. Two opposition (SLFP) parliamentarians namely, Mangala Samaraweera (MP of Matara) and Mahinda Rajapakse (current president of Sri Lanka then MP of Hambantota) inaugurated the Mothers' Front in the southern town of Matara, demanding the

⁵²⁹ Malathi de Alwis, 'The Moral Mother Syndrome', *Indian Journal of Gender Studies*, 2004:11(1), p. 69.

⁵³⁰ Ibid.

⁵³¹ See Neloufer de Mel (2007) for an insightful analysis on women's bodies in the militarised neo-liberal state of Sri Lanka.

⁵³² <http://www.womenandmedia.net/network/MDL.htm> (Accessed on 9 November 2011) and de Mel, *Women and The Nation's Narrative*, p. 238.

government to look for the 'disappeared' (*athurudanvuo*).⁵³³ The opposition organised the southern Mothers' Front to pressurise the government to do its patriarchal duty towards the nation by looking for 'disappeared sons'. Dr Manorani Saravanamuttu, mother of Richard de Soyza broadcaster and journalist killed by the JVP on 18 February 1990, became the president of the national committee of the Mothers' Front. Although Tamil by ethnicity, her urban upper middle class identity and marriage into a prominent Sinhala family disqualified her to represent Tamil nationalism. Her desire was 'not to be anti-government in anyway' but 'to act as peaceful watchdogs'.⁵³⁴

However, by using the emergency law the minister of state for defence, Ranjan Wijeratne, banned the political demonstrations of the Mothers' Front as it was creating indiscipline and chaos. 'We want democracy through good behaviour. This government will not tolerate indiscipline any longer.'⁵³⁵ The government criticised the Mothers' Front blaming its members for not bringing up their sons properly so that the government had to establish camps to rehabilitate them. This implies that the government felt forced to take over the responsibility which was traditionally assigned to mothers. Ranjan Wijeratne explained: 'Mothers are not expected to stage demonstrations. Mothers should have looked after their children. They failed to do that. They did not know what their children

⁵³³ De Mel, *Women and The Nation's Narrative*, p. 244. Samaraweera and Rajapakse were inspired by the Mothers' Front of Argentina's Plaza de Mayo to organise the Southern Mothers' Front in Sri Lanka.

⁵³⁴ 'Mothers' Front pro-peace, not anti-govt', *Daily News* 20 Feb. 1991, p. 10.

⁵³⁵ 'Political meetings, picketing, but no demos – Ranjan', *Daily News*, 15 Feb. 1991, p. 1

were doing. They did not do that and now they are crying.’⁵³⁶ By ‘looking after’, he implied that mothers should be able to stop their sons from becoming revolutionaries. Since mothers failed to do so, the government had to take on the responsibility and rehabilitate the youth. In other words, the government assumed its full responsibility exercising the paternal power of protecting its women and children.

The Mother’s Front soon expanded its membership to 25,000. The group engaged in activities initiated by the SLFP such as *pada yathra* (walks), weeping, cursing and breaking coconuts (*pol gaseema*). In Sri Lankan society where funeral rites are performed over a period of seven days, there is a specific cultural and emotional value to the dead body. To the mothers, the ‘absence of bodies’ signified the failure of the patriarchal state to provide protection to their children. In support of the Mothers’ Front, Mrs Bandaranaike, the leader of the opposition, in her address at the International Women’s Day in 1990 accused the government for making mothers live in fear and agony.⁵³⁷

As a counter action, Mrs Hema Premadasa, the first lady, used her position as the president of the *Seva Vanitha* Movement (1988–93) to create another ideology, the ‘Nurturing Mother of the Nation’. Espousing traditional women’s duty and role in society, she carried out activities such as providing lunch for the soldiers in the battlefield, which was much more than the charitable projects her

⁵³⁶ Daily News, 15 Feb. 1991, quoted in de Alwis, ‘Motherhood as a Space,’ p. 188.

⁵³⁷ ‘Mothers now live in fear and agony, says Mrs. B’, *The Island*, 9 March 1990, p. 1.

predecessor carried out.⁵³⁸ In response to the opposition party's (SLFP) Mothers' Front, the party in power (UNP) formed its own Mothers' Front in 1992 answering with 'counter-rhetoric, counter-rallies and counter-ritual.'⁵³⁹

Even though the Southern Mothers' Fronts did not intend to have any political affiliations, it was not possible due to the political unrest in the country. Thus two Mothers' Fronts were mobilised carrying the two main political ideologies (SLFP and UNP) of the day. Like the Northern Mothers' Front which was disbanded in 1986, the Southern Mothers' Fronts also lost their vigour in 1993. Clearly, both southern Mothers' Fronts were used by political parties (SLFP and UNP) to achieve their political goals, but their public protest activities created a new public space for women where they could present their issues. When considering the activities of the Mothers' Fronts, it is apparent that they redefined women's traditional limits and helped women cross the boundary between private and public. They also mobilised the notion of motherhood for unfeminine public demonstrations but within a highly traditional framework. By saying so, I do not suggest that the boundary between private and public does not exist anymore in women's social role in Sri Lanka, but it has become more permeable. One other important aspect of the two southern Mothers' Fronts was that since the SLFP and UNP were addressing Sinhalese Buddhist sentiments through these organisations,

⁵³⁸ De Mel, *Women and The Nation's Narrative*, p. 146.

⁵³⁹ Malathi de Alwis, 'Motherhood as a Space of Protest' in Patricia Jeffery and Amrita Basu (eds), *Appropriating Gender: Women's Activism and Politicized Religion in South Asia*, NY/London, Routledge, 1998, p. 188. (pp. 186–201).

these groups did not represent any other ethnic or religious community in the country.

At the same time, the state was not only enhancing, valorising, but also patronising motherhood due to the increasing number of female headed households created by the conflict situation in the country.⁵⁴⁰ I believe that the veneration and admiration of motherhood (whether Sinhalese or Tamil) pushed Sri Lanka further away from the programme of the Cairo conference, paralysing women's health from moving towards a rights based approach and standing up for women's rights.

Concluding Thoughts

The 1990s was marked by a fading mutual understanding between the international development and population control agenda and the women's health agenda of Sri Lanka. This happened due to the disconnect between the ideology shift the ICPD proposed on women's health (from family planning to reproductive health and rights) and the way the Sri Lankan state re-defined and mobilised women's bodies for a traditional social reproductive role.

By illustrating this disconnect between the shift in the global agenda on women's health and the state's discourse on woman's body (through notions of docile girls, responsible mothers and brave mothers of the nation) in the 1990s,

⁵⁴⁰ See Thiruchandran, *The Other Victims of War*, 1999, for an analysis of how the concept of breadwinner of traditional patriarchal household changed with the war situation in Sri Lanka.

this chapter sets up the following chapter which tries to bring the discourse on women's health and woman's body into a unified discursive frame.

Chapter Five

Reproductive Health and Rights in Post-ICPD Sri Lanka

Abstract

As proposed at the International Conference on Population and Development (ICPD), with the aim of moving towards a comprehensive women's health agenda formulated on the global stage, Sri Lanka launched two policy initiatives in the midst of economic transformation and political turmoil in the 1990s. They were the Well Woman Clinic programme (WWC) in 1996 and the Population and Reproductive Health (PRH) Policy in 1998.

Scholars such as Halfon, Simon-Kumar, Rao and Petchesky who have been involved in the review of women's health programmes designed after the Cairo conference in different parts of the world, have contended that the basic needs and human rights approach of the Cairo rhetoric has not been fully translated into the actual policies and programmes. Sri Lanka launched the first WWC programme in South Asia in 1996 endorsing her success story status. However, I argue that Cairo is a half realised dream within the post-ICPD women's health discourse of Sri Lanka for three reasons. First, in an atmosphere where human rights were constantly infringed in Sri Lanka in the 1990s, the upholding of reproductive rights was unlikely if not impossible. Second, due to the controlling and planning mindset of health policy makers who reigned for decades, there was no hope for developing and delivering a comprehensive women's health agenda 'beyond reproduction'. Third, when the state reframed women's bodies within social reproduction roles as a response to the turbulent events of the 1990s, women, bureaucrats and doctors were not free to 'imagine' the new ideology of women's health 'beyond reproduction' in 1996.

By reading the PRH policy against the grain, I show that Malthus's presence is felt stronger in the PRH policy than ever before, even though the ICPD Programme of Action proposed to emancipate women's health by granting reproductive health and rights to women.

Introduction

Amidst the economic transformation and political turmoil of the last decade of the twentieth century discussed in the preceding chapter, the state launched two ambitious women's health policy initiatives. One of them was an island-wide Well Woman Clinic (WWC) programme launched in 1996, and the other a Population and Reproductive Health policy (PRH) designed in 1998. Both these initiatives were adopted in response to the International Conference on Population and Development (ICPD or Cairo) held in Cairo in 1994. Cairo was widely hailed for its call to end the prevailing coercive, target-based approach to population control in favour of an approach that centred on reproductive health and rights.⁵⁴¹ This chapter discusses how the post-Cairo WWC programme and PRH policy emerged at the same moment as the state was framing women's bodies around motherhood. In particular, this chapter examines the ideological products of this conjunction. While the WWC programme and the PRH policy attempted to shift the narrow family planning focus on women's health to a reproductive health and rights agenda—which I call 'beyond reproduction'—the state was framing women's bodies within a discourse of social reproduction and motherhood in response to the turbulent events of the 1990s (described in Chapter Four). This chapter examines how a women's health ideology 'beyond reproduction' worked alongside the state's ideology of 'motherhood' (essentially framed around social reproduction) in 1990s Sri Lanka.

⁵⁴¹ A.T.P.L.Abeykoon, 'ICPD 15 Years On: Sri Lanka's Participation, Policy and Programme Initiatives' in Bradman Weerakoon (ed.), *ICPD – 15 Years On' Sri Lanka*, p. 8.

However, the WWC programme is puzzling. Although the ICPD proposed to introduce a reproductive health and rights approach to women's health, there is no mention of reproductive rights in the materials published by the Family Health Bureau (FHB) of Sri Lanka on the WWC programme. The WWC policy solely emphasises reproductive health. Further, with reference to preventing disease by screening women's bodies against 'common non-communicable diseases such as hypertension and diabetes, breast malignancies and cervical cancers' the material published by the FHB affirms that the WWC programme introduced a reproductive health approach to women's health, whilst saying nothing about reproductive rights.⁵⁴² The PRH policy presents a similarly puzzling disjuncture. As mentioned in Chapter One, even though the Sri Lankan State had identified the need for a population policy at the beginning of the 1950s, the PRH policy document was not produced until almost half a century later (in 1998); Sri Lanka had already reached replacement level fertility four years earlier (in 1994). The PRH policy was also silent on reproductive rights and targets, it aimed instead to 'achieve a stable population size at least by the middle of the 21st Century.'⁵⁴³

As policy initiatives, both the WWC programme and the PRH policy were problematic because neither mentioned reproductive rights. Nevertheless, they jointly represented a move to embrace a new era in global women's health policy that was characterised by reproductive health and reproductive rights. In

⁵⁴² *Annual Report on Family Health Sri Lanka 2004–2005*, Colombo, 2007, p. 31.

⁵⁴³ *Population and Reproductive Health Policy 1998*, Ministry of Health and Indigenous Medicine, Sri Lanka, p. 28.

principle, these policies might have moved 'beyond reproduction' (by freeing women's bodies from reproducing the nation and by treating them as human bodies possessing individual rights as citizens of Sri Lanka). However, these initiatives came at a time when the state was casting women as responsible and brave mothers within the nation-building project of the turbulent 1990s. As a result, this new veneration of motherhood precluded the women's health programme from adopting a comprehensive women's health approach. Thus, it raises the question, is it possible to promote reproductive rights in the absence of human rights?

The aim of this chapter is to comprehend Sri Lanka's WWC programme and PRH policy alongside both global health policy initiatives and Sri Lankan political imperatives. As a result, this chapter is structured around the multiple disconnections that the WWC programme and PRH policy produced, at global, national and corporeal levels. I used material collected from interviews conducted with the architects, implementers and users of these programmes to show these multiple disconnections. I contend that these disconnections stem from an understanding of the discourses on women's health and woman's body which sees them as separate entities existing in different territories and epistemes, disregarding the mutual inclusiveness of the two.

Since both these policy initiatives are a consequence of the ICPD in Cairo, it is necessary that I begin by providing a brief history of the international conferences held to discuss population and development issues. Thereby, I will

discuss the new shift in women's health—from family planning to reproductive health and rights—proposed at the ICPD, and its effect on the women's health programme in Sri Lanka. I will then discuss the WWC and the PRH policies in turn. The 'Cairo consensus' finally drafted a global strategy which had begun two decades earlier (in 1974). This consensus claimed that population control was a necessary precondition for development.⁵⁴⁴ Even though the Cairo consensus was produced after much deliberation and lobbying by women's groups and civil society organisations, there has been a plethora of critical work written about Cairo. However, a majority of these works agree that Cairo was a watershed moment for contemporary discourses on population, development and women's health.⁵⁴⁵

ICPD Cairo: From Family Planning to Reproductive Health and Rights

The first International Population Conference of official, governmental nature was held in Bucharest, in 1974. It was attended by representatives of one hundred and thirty-five countries.⁵⁴⁶ Representatives of India came up with an innovative slogan 'development is the best contraceptive,' and requested First World Nations

⁵⁴⁴ Sarah Hodges, 'Review Article: Malthus is Forever: The Global Market for Population Control', *Global Social Policy*, 10:2010, p. 124.

⁵⁴⁵ See Simon-Kumar (2006), Halfon (2007), Hartmann (1995), Johnson (1995), Petchesky (1999).

⁵⁴⁶ Stanley Johnson, *The Politics of Population: The International Conference on Population and Development Cairo 1994*, London, Earthscan, 1995, p. 17. (Though UN sponsored population conferences were held before 1974 at Rome in 1954 and Belgrade in 1965 they were mainly scientific conferences where experts gathered to discuss the impact and implications of population).

to help the Third World in achieving their development goals.⁵⁴⁷ No overall global targets for population growth were set. However, by the late 1970s the two most populous countries in the world, India and China, had implemented austere population control measures which some claimed were the direct results of such a 'developmentalist' approach.⁵⁴⁸ India introduced 'Sterilisation Camps,' and China introduced the 'One Child Policy,' in 1978.⁵⁴⁹

The second International Population Conference was held in Mexico ten years later. The secretary general of the 1984 conference and executive director of the UNFPA, Rafael Salas, made an explicit commitment to set a specific target in Mexico. He declared: 'Our goal is the stabilisation of global population within the shortest period possible before the end of the next century.'⁵⁵⁰ Even though the 1974 and 1984 conferences did not produce a concrete plan of action, they contributed in numerous ways to the shaping of a global discourse on population and development.

The third decennial conference was held in Cairo, in 1994. One hundred and seventy nine countries pledged to incorporate reproductive health and rights measures in their women's health programmes. The Cairo Programme of Action (PoA) urged a move away from coercive measures of population control towards a

⁵⁴⁷ Rachel Simon-Kumar, *'Marketing' Reproduction? Ideology and Population Policy in India*, New Delhi, Kali for Women, Zubaan, 2006, p. 5.

⁵⁴⁸ Saul Halfon, *The Cairo Consensus: Demographic Surveys, Women's Empowerment, and Regime Change in Population Policy*, Lanham/Boulder/New York/Toronto/Plymouth, Rowman & Littlefield Publishers, 2007, p. 66.

⁵⁴⁹ Simon-Kumar, *'Marketing' Reproduction?*, p. 102 and Johnson, *The Politics of Population*, p. 18.

⁵⁵⁰ Johnson, *The Politics of Population*, p. 20.

new emancipated reproductive health and rights agenda.⁵⁵¹ Unlike the previous decennial conferences, the ethos of the Cairo marked a definite shift in the global agenda on women's health—from a Malthusian focus on population control to a broader concern with reproductive health and rights.⁵⁵² Scholars have noted that the language of Cairo clearly 'downplays' and 'undermines' the significance of the term 'population', affecting a rhetorical shift from 'population control' to 'women's empowerment'.⁵⁵³ This paved the way for a wide range of policy discourses and practices.⁵⁵⁴

Petchesky suggests that the significance of Cairo's Programme of Action was threefold. In addition to enacting a move away from narrow demographic targets to a reproductive health approach, Cairo also integrated 'the principles of gender equality, equity and women's empowerment into population and development strategies' and explicitly recognised 'reproductive rights, very broadly defined and linked to primary health care, as fundamental human rights'.⁵⁵⁵ Betsy Hartmann points out that the other significant outcome of Cairo was to affect the emergence of a liberalising market agenda to govern women's

⁵⁵¹ By the early 1990s reproductive centred women's health started to expand especially in the US. 'The Breast and Cervical Cancer Mortality Prevention Act of 1990 authorized the Centres for Disease Control and Prevention (CDC) to establish the National Breast and Cervical Cancer Early Detection Program to improve access to screening services for low-income, uninsured, and other underserved women. See Carol S. Weisman, 'Changing Definitions of Women's Health: Implications for Health Care and Policy', *Maternal and Child Health Journal*, 1:3(1997), p. 182, for details of the expansion of the definition of women's health.

⁵⁵² Simon-Kumar, *'Marketing' Reproduction?*, p. 2.

⁵⁵³ Halfon, *The Cairo Consensus*, p. 67.

⁵⁵⁴ Ibid., p. 4

⁵⁵⁵ Rosalind P. Petchesky, *Global Prescriptions: Gendering Health and Human Rights*, London/New York, Zed Books, 2003, p. 35.

health and bodies.⁵⁵⁶ Further she argues that the ICPD had ‘sold’ the idea of encouraging small families through motivational efforts by making coercion implicit and repackaging it as a ‘consumer choice.’⁵⁵⁷

In the context of India, Simon-Kumar says the ICPD influenced the shift ‘from an incentive-based to a target-free approach, from population control to reproductive agency’ and ‘from numerical quotas to informed choices’ as a way of explaining how the post-Cairo reproductive and child health policy of India became a ‘missed chance’ rather than a feminist policy.⁵⁵⁸

Following Hartmann and Simon-Kumar, I investigate how Sri Lanka’s WWC and PRH policies ‘translated’ Cairo’s ‘achievements’ during the 1990s. The leader of the Sri Lankan delegation to the ICPD Cairo, Deshamanya Bradman Weerakoon, described the Cairo consensus as a set of guidelines to plan and implement population programmes

from primarily, societal goals to individual rights; from family planning to reproductive health and reproductive rights; from population reduction to women’s health and the welfare of women, men and children; and from vertical health service delivery to integrated services.⁵⁵⁹

In line with this paradigm shift, the WWC programme was introduced as a reproductive health initiative to address women’s health ‘beyond reproduction’.⁵⁶⁰

Further, to the credit of the women’s health ‘success story’, Sri Lanka was the first

⁵⁵⁶ Hartman, *Reproductive Rights and Wrongs*, p. 153.

⁵⁵⁷ Ibid.

⁵⁵⁸ Simon-Kumar, *Marketing Reproduction?*, p. 151.

⁵⁵⁹ Weerakoon, ‘Introduction and overview’, p. xi

⁵⁶⁰ *Suvanari Seva Athpotha* (Handbook about setting up of WWCs), Colombo, Family Health Bureau, 2003, in the preface.

in South Asia to launch a government-run WWC programme.⁵⁶¹ The government's stated aim in launching its WWC programme was to introduce the concept of reproductive health in order to enhance women's health in Sri Lanka. (*Suvanari sayana kanthavange saukya thathvaya nagasituveema aramunu karagena prajanana saukya sankalpaya yatathe kriyathmaka karanalada nawa sayanika sevavaki*).⁵⁶² Despite the political turmoil of the 1990s, Sri Lanka launched an island-wide WWC programme in 1996.

Well Woman Clinics

Although Well Woman Clinics were new to Sri Lanka in 1996, the concept had been in existence since the 1940s.⁵⁶³ Such clinics were initially developed as an extension of preventive medical care in the United States. Its promoters claimed that these clinics originally afforded healthy women 'who claimed to be free of complaints' an opportunity to undergo a 'routine medical check up' in the US and Canada.⁵⁶⁴ WWCs were also introduced in the United Kingdom between the late 1960s and early 1970s.⁵⁶⁵ These WWCs were

set up to screen women for cervical cancer and breast abnormalities. They then developed into "Well-Woman" clinics with the addition of other investigations (urinalysis, blood pressure estimation, haemoglobin estimation, pelvic examination, and a general check-up), and by

⁵⁶¹ Malathi Weerasooriya, 'Global Partnership for Population and Development' in Bradman Weerakoon (ed.), *ICPD – 15 Years On' Sri Lanka*, p. 69.

⁵⁶² *Suvanari Seva Athpotha*, p. 1. (Translation from Sinhala to English is mine).

⁵⁶³ J.P.A. Latour, H.Oxorn and N.W. Philpott, 'An Assessment of the Value of a Well Woman Clinic', *Canadian Medical Association Journal*, 67(Nov. 1952), p. 439.

⁵⁶⁴ *Ibid.*, p. 439.

⁵⁶⁵ Katy Gardner, 'A well woman clinic in an inner-city general practice', *Journal of the Royal College of General Practitioners*, 1983, November, p. 711.

allowing women to discuss any problems they might have with the clinic doctor.⁵⁶⁶

The first National Conference on WWCs was held in Manchester, in 1981. It was convened by the National Association of Community Health Councils in order to bring together the various groups providing such clinical services.⁵⁶⁷

Well Woman Clinic Programme of Sri Lanka – 1996

The WWC programme was launched in Sri Lanka in 1996 as a consequence of the ICPD. It came under the auspices of the Family Health Bureau, the central organisation of the Ministry of Health (MOH) responsible for planning, coordinating, monitoring and evaluating the Maternal and Child Health (MCH) and Family Planning programme in Sri Lanka.⁵⁶⁸ The stated objective of the WWC programme was,

Avurudu 35ta vædi kanthavan muhunapæhæki pradhana rogi thathvayan kihipayak handunagæneemen ovunge saukya thathvaya vædi diyunu kireema mema vadasatahane aramunai [to improve women's health by early detection of common, non-communicable diseases such as hypertension, breast cancer, Diabetes Mellitus and cervical cancer of women who are past their reproductive age of 35 years].⁵⁶⁹

⁵⁶⁶ Marioth Manche, 'The Effectiveness of the Chester "Well-Woman" Clinics' (unpublished thesis), Faculty of Medicine, University of Manchester, 1988, p. 1.

⁵⁶⁷ Gardner, 'A well woman clinic', p. 711.

⁵⁶⁸ Family Health Bureau (FHB) of Sri Lanka was set up in 1968.

⁵⁶⁹ General Circular, 1996 Aug. 19. p. 1-2.

As in the West where it originated, WWCs were set up in Sri Lanka within the sphere of preventive medicine as 'screening centres' and not centres for treatment.⁵⁷⁰

Since the inception of the programme, the FHB has issued three circulars and published one handbook providing guidance on how to implement the WWC programme.⁵⁷¹ WWCs function at the base of the well-structured public health system in Sri Lanka (i.e. Health Unit). They provide free medical access to women from every strata of society. The Medical Officer of Health (MOH) is responsible for preventive and promotional health care in a defined area known as a Health Unit. Currently, there are 280 health units in Sri Lanka headed by a MO/MCH carrying out preventive care services.⁵⁷² The first WWC was set up in June 1996 in the Kalutara District in the Western Province of Sri Lanka.⁵⁷³ By the end of 2007, 611 WWCs were functioning in the country, based mostly at pre-existing MOH health centres.⁵⁷⁴ The number of women attending the clinics increased from

⁵⁷⁰ Guidelines for Operationalizing Well Woman Clinic Programme, circular dated 22nd Feb. 1997, p. 1.

⁵⁷¹ These three circulars are; General Circular No. 1926 dated 19th August 1996, Guidelines for Operationalising the WWC programme dated 22nd February 1997 and Guidelines for Implementation of the WWC programme dated 14th July 1999.

[I wish to express my gratitude to Dr Chithramali de Silva and Dr Sanjeewani Karunarathna of Family Health Bureau, Sri Lanka for locating these documents for me. These circulars were addressed to all the key government officials in the public health sector.]

⁵⁷² De Silva A.P. 'The Services functions and Utilisation patterns of a newly implemented Well-men Clinic in a selected Medical Officer of Health Area', 2007, unpublished MA thesis to Post Graduate Institute of Medicine, Colombo, p. 14. The first Health Unit was set up in Kalutara in 1926 and the second in Weudawili, Hatpattu in the North Western Province in Nov. 1927, and the third in Matara in the Southern Province in May 1928. (Uragoda 1987:163).

⁵⁷³ Wijesinghe, C.J., 'Descriptive Study on women attending WWCs in the Galle District', unpublished PhD thesis submitted to the Postgraduate Institute of Medicine, Colombo, 2003, p. 8.

⁵⁷⁴ *Annual Report on Family Health Sri Lanka 2006-2007*, Colombo, Family Health Bureau, 2009, p. 21

61,707 in 2004 to 113,712 in 2007.⁵⁷⁵ However, the FHB notes that only 18 percent of women who attend are over 35 years of age.⁵⁷⁶

Even though the leader of the Sri Lankan delegation to the ICPD in Cairo identified reproductive rights as a concept that Sri Lanka should introduce in order to uplift women's health in the country, surprisingly, I did not come across the term 'reproductive rights' in any of the official documents relating to the WWC programme published by the FHB.

Did Reproductive Rights Miss the Flight From Cairo?

Is the absence of reproductive rights in government rhetoric a 'mistake or an oversight' on the part of the Government, or is it a deliberate policy decision made at the level of implementation? I see this absence of reproductive rights both as an 'official oversight' and 'official impasse' of 1990s Sri Lanka.

The term 'reproductive rights' was not coined at the ICPD in Cairo; rather, it emerged during the 1980s as a consequence of the second wave of feminism in the 1970s largely generated by the women's movements in North America,

⁵⁷⁵ Ibid., p. 22.

⁵⁷⁶ Ibid, WWCs are operated in four settings in Sri Lanka. They are at MOH health centres and government base hospitals offering free medical services to the public. Private hospitals and private institutions geared towards health and wellness offer different health packages to undergo tests done at WWCs. Apart from these institutions the FPA of Sri Lanka established a WWC in December 1997 within its reproductive health initiative. Since the majority of the population depend on public health services in Sri Lanka and also because I am analysing the government policy documents in this chapter I will limit my study to the government WWC programme and the beneficiaries of the government health care system.

Europe, Australia and Latin America.⁵⁷⁷ Petchesky points out that, women's rights movements in both the global North and South developed and expanded the concept of reproductive health and sexual rights through 'cross fertilisation of ideas –across many countries and continents' during the 1990s.⁵⁷⁸ They were brought onto international platforms at the World Conference on Human Rights in Vienna in 1993, the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995.⁵⁷⁹

Even though the Annual Reports of the FPA have explicitly articulated the concept of reproductive rights in the gender equity and women's empowerment programme that began in 1997, it was carefully omitted from the official rhetoric of women's health in Sri Lanka.⁵⁸⁰ I would be a careless reader of official documents if I were to brush this off as a 'mistake' made by the FHB. Rather, I see this primarily as an 'official oversight' due to the over-emphasis placed on demographic indicators. Second, I see this omission as an 'official impasse', wherein the state was incapable of producing a reproductive rights discourse at a time when human rights were undermined.

⁵⁷⁷ <http://www.ghwatch.org/sites/www.ghwatch.org/files/B4.pdf> (Accessed on 15 June 2011).

⁵⁷⁸ Rosalind P. Petchesky, 'Introduction' in *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures*. Rosalind P. Petchesky and Karen Judd (eds), London/New York, Zed Books, 1998, p. 3 (pp. 1-30).

⁵⁷⁹ Ibid., p. 3.

⁵⁸⁰ *Annual Report of Family Planning Association '97- '98*, Colombo, FPA, 1999, p. 24.

Reproductive Rights as an ‘Official Oversight’

In the context of Sri Lanka’s demographic history, the policy shift from family planning to reproductive health sounds—ostensibly—convincing, considering that Sri Lanka had achieved replacement level fertility in 1994. So that by 1996 the state could claim that population was no longer a ‘problem’ for development.⁵⁸¹ Deshamanya Bradman Weerakoon, leader of the Sri Lankan delegation to Cairo, also attested in his speech at the ICPD that, ‘Sri Lanka has reached the final stage of its demographic transition. The annual rate of population growth has come down to 1.2 per cent, the total fertility rate is 2.2 and the life expectancy for women is almost 75 years.’⁵⁸² Therefore, after the Cairo conference, the establishment of the WWC programme as a reproductive health initiative appeared—according to demographic and developmental thinking—the logical and best step forward.

However, when I asked officials at the FHB why Sri Lanka decided to launch a WWC programme at this particular moment, I received very vague answers, such as ‘After the ICPD [the] Minister of Health decided to launch it and [the] UNFPA provided technical and financial assistance, so here we are with WWCs.’⁵⁸³ Nevertheless, it provides some insight into the day-to-day workings and decision-making processes of the FHB. It also depicts the usual lack of

⁵⁸¹ By 1995 Total Fertility Rate has come down to 1.9, which is below population replacement level. www.statistics.gov.lk/PopHouSat/index.asp and www.statistics.gov.lk I have discussed details of the replacement level fertility in Chapter Two of the thesis.

⁵⁸² Johnson, *The Politics of Population*, p. 196.

⁵⁸³ Interview with the National Programme Manager Gender and Women’s Health (in-charge of WWC programme) at the FHB. Colombo, 26 March 2010 at her office.

resources (monetary and expertise/technology) story of the Third World.⁵⁸⁴ This was a decision made from above (first at Cairo and then by the minister of health), hence the officials were compelled to implement it without further questioning or deliberation. Additionally, the FHB doctors involved with the launching of the WWC programme confided in me that it was indeed a ‘mistake’ to launch a national programme without conducting a feasibility study. During my discussions with the WWC programme designers and implementers it was evident that the inception of the WWC programme was mainly a political decision taken by the then honourable Minister of Health and Nutrition Mr A.H.M. Fowzie. For policymakers and implementers, the ‘mistake’ was a procedural one: failing to conduct a feasibility study prior to implementing an island-wide WWC programme. But, what is at stake in this mistake? I find all these procedural mechanisms rather meaningless when policymakers turn a blind eye to the larger picture that has serious implications for women’s health and bodies. From my interviews with the policymakers of the WWC programme, it was clear that they did not recognise that the conceptual shift proposed at the ICPD should have been reflected in the WWC programme. They were simply interested in implementing orders from above, and in procedural mechanisms of programme implementation. In short, the FHB of Sri Lanka launched the WWC programme in 1996 without engaging with the conceptual/ideological shift that the ICPD was supposed to

⁵⁸⁴ Critics of development aid programmes such as Bastian (2007) point out how development acquired different nuances due to these issues at implementation level.

have enacted because of the way in which funds and technical support came from the UNFPA: in a neat technocratic package.

When I posed the same questions [Why did Sri Lanka decide to launch a WWC programme in 1996? Do you think Sri Lanka was ready to launch the WWC programme then?] to the present WWC programme director of the UNFPA, she evaded the question by saying that, 'it is a chicken and egg situation.' According to her, I was asking the wrong set of questions.⁵⁸⁵ She explained that:

The important thing about the WWC programme is how it performs today. Not about questioning its timing. When introducing a new programme it is very difficult to say how it will be received by the public. So whether we should wait until the time is ripe to launch the WWC programme or whether we should launch the programme and make it happen is a very intricate question.⁵⁸⁶

According to her, the most important thing about the WWC programme is its performance: for Sri Lanka to be the first in South Asia to launch an island-wide WWC programme through the government healthcare sector.⁵⁸⁷ By 'performance', she meant encouraging more women to attend WWCs to be examined in order to detect common, non-communicable diseases. She then spoke of the WWC programme in laudatory terms, emphasising its operation even within the war zone during the ethnic conflict. She emphasised that

⁵⁸⁵ Since it is unusual for a historian to inquire about women's health policies, I frequently encountered this type of hostile responses from medical doctors in Sri Lanka.

⁵⁸⁶ Interview with the present WWC programme director of the UNFPA, 17 August 2011 at the UNFPA Colombo Office.

⁵⁸⁷ Ibid.

The WWC programme is a government programme. The UNFPA is only providing technical support in terms of training the pathologists and cytologists and also the screening procedures and equipment. The monetary contribution is insignificant.⁵⁸⁸

During the interview she clearly placed the donor (UNFPA) and recipient (Government of Sri Lanka, in this case the FHB) within an international discourse on women's health by defining each party's role by the limited support provided by the UNFPA.

From my conversations with officials at the FHB and the UNFPA, it is clear that both these institutions (FHB and the UNFPA) have clearly demarcated their respective positions and defined their implementation procedures within the WWC programme, but have not made any effort to understand the paradigm shift that the ICPD calls for within the WWC programme or considered how it would affect women at the grassroots level. I reckon that the FHB and UNFPA officials were too eager to make this shift in order to be the first in South Asia to do so, thus upholding Sri Lanka's long-standing record in possessing the best women's health indicators in the region. In their eagerness, officials 'overlooked' the concept of reproductive rights, making the WWC programme a half-realised dream of a post-ICPD women's health programme for Sri Lanka. After achieving replacement-level fertility, the next demographic step was to adopt a comprehensive women's health approach by shifting from family planning to

⁵⁸⁸ Ibid.

reproductive health. Conferring reproductive rights to women was not seen as a demographic necessity.

Reproductive Rights as an 'Official Impasse'

I see this omission of reproductive rights as an 'official impasse' wherein the state was incapable of producing a reproductive rights discourse at a time when human rights were undermined by the state. Analysing the Cairo Programme of Action, Petchesky points out that reproductive rights (in a very broad sense) are defined by and linked to fundamental human rights.⁵⁸⁹ In the absence of Sri Lankans enjoying fundamental human rights it is hardly surprising that, in the 1990s, women's reproductive rights (that is the right to make decisions about one's reproductive body free from direct or indirect coercion) would be included in an official policy or everyday bureaucratic practice. Discussing women's activities in 1990s Sri Lanka, a feminist scholar says, 'women's groups had to keep the issues of domestic violence, sexual harassment, equal opportunities, abortion, women's access to safe contraception and informed choice about contraceptive methods, women's reproductive health, the image of women in the media etc. on hold' due to the socio-political crisis within the country in the 1990s.⁵⁹⁰ Supporting de Mel's argument, an eminent lawyer points out that a bill to broaden the exceptions and permit abortion 'in the event of rape, incest or grave foetal defects' was withdrawn

⁵⁸⁹ Rosalind P. Petchesky, 'From Population Control to Reproductive Rights: Feminist Fault Lines', *Reproductive Health Matters*, 3: 6(Nov. 1995), p. 153.

⁵⁹⁰ De Mel, *Women and The Nation's Narrative*, p. 235.

under pressure from religious groups in 1995, even before it was tabled in parliament.⁵⁹¹ This confirms that reproductive rights were positioned far away from the sealed doors of human rights in 1990s Sri Lanka.

Furthermore, the 'official impasse' to confer reproductive rights to women could be clearly seen in the FHB officials' attitude towards women. During my conversations with the policymakers of the WWC programme at the FHB, the idea of denying rights when offering a free service came up frequently. This is aptly expressed in the common Sinhala idiom *nikam dena assayage dath balanne næne*, which means 'never look a gift horse in the mouth.' When reproductive health is provided as a free service, government officials did not (and do not) see reproductive rights as women's rights which the government should confer on them. The long history of welfareism in Sri Lanka made women beneficiaries of the public health system, which in turn made them indebted to the state for what they were receiving free of charge. Consequently, they became ignorant of their rights as citizens. In her analysis of the importance of social welfare policies for the lives of Scandinavian women, Hernes deals with a very intriguing question (that also applies to the welfare health policy of Sri Lanka), which is

whether women's status as clients and their political profile as recipients has prolonged and institutionalised their powerlessness, or whether the minimum livelihood that the welfare state has guaranteed

⁵⁹¹ Savithri Goonesekere, 'Gender, Equality and the Empowerment of Women in Sri Lanka' in Bradman Weerakoon (ed.), *ICPD – '15 Years on' Sri Lanka*, p. 30. In fact the criminal offence of abortion has existed unchanged in Sri Lanka since it was introduced to the Penal Code by the British in 1883 under Section 303 http://www.commonlii.org/lk/legis/consol_act/pc25130.pdf (Accessed on 5 October 2012).

them has given them the opportunity and the resources to wage their war of independence.⁵⁹²

From my interviews, it is clear that their prolonged 'beneficiary' status caused women to 'institutionalise their powerlessness'. As shown in Chapter Three, free distribution of the Pill by the midwives is a clear indication of women's powerlessness within the public health system. This situation further deteriorated in the 1990s, once women were considered national objects, thanks to the biological and social reproductive role conferred upon them. The institutionalisation of women's powerlessness in Sri Lanka in the context of women's health occurred both due to the longstanding 'beneficiary' ideology held by many women, and the state's paternalistic approach towards women's issues. As discussed in the preceding chapter, the premise of the state framing women's bodies during the 1990s was a particularly paternalistic attitude towards women subjects. This in turn precluded the state from perceiving women as citizens, creating an 'official impasse' to grant reproductive rights to them.

Leaving such contentious issues as marital rape, domestic violence, and legalisation of abortion unaddressed, the state ostensibly designed the WWC programme around the notion of reproductive health. The WWC programme was launched as a screening mechanism to detect common non-communicable diseases among women over thirty-five years of age, conveniently ignoring the reproductive rights aspect of the ICPD resolution. Finally, the WWC programme

⁵⁹² Hernes, *Welfare State and Woman Power: Essays in State Feminism*, Oslo, Norwegian University Press, 1987, p. 27.

became a half-realised dream of a post-Cairo women's health programme in Sri Lanka because reproductive rights were not incorporated. This was a result of State officials failing to see reproductive rights as human rights, during the 1990s.

How successful was the concept of reproductive health introduced through the WWC programme in Sri Lanka? In order to understand how it was introduced and implemented, I interviewed policy makers of the FHB, implementers and ten women in two WWCs in the Dehiwala MOH area.

Introducing Reproductive Health through WWCs

During the conceptualisation of WWCs, its architects identified three key components of the WWC programme:

First and foremost WWC is a women's clinic 'beyond reproduction.' Secondly, we wanted to introduce the idea of 'prevention' through screening. So WWCs are for women to be screened periodically to detect common non-communicable diseases, such as cervical and breast cancer, diabetes and hypertension. Thirdly, we wanted to establish that WWCs are not to cure any disease but a clinic for healthy women.⁵⁹³

According to this articulation, the WWC programme was clearly a step forward from family planning (which was essentially centred on population control) in Sri Lanka, towards a comprehensive women's health approach. Through my in-depth interviews with women attendees at two WWCs (Attidiya and Kotalawalapura) in

⁵⁹³ Interviewed the National Programme Manager Gender and Women's Health (in-charge of the WWC programme) at the FHB on 26 March 2010 at the FHB and one of the contributors for the *Suvanari Seva Athpotha*, lecturer at the Faculty of Medicine, University of Colombo 30 March 2010.

Dehiwala, I will explore how each of these three articulations gained meaning at the grassroots level, within the WWC programme.

WWC as a Clinic 'Beyond Reproduction'

'Beyond reproduction' is a novel concept not only within women's health discourses but also discourses on women's bodies in Sri Lanka. As I mentioned in the introductory chapter, although Sri Lankan women have a commendable literacy rate, they were not emancipated through education because women's education was geared more towards producing 'presentable housewives'—a social reproductive role—than empowering women.⁵⁹⁴ Education did not equip women with the essential tools to think 'beyond' the social reproductive role that they were traditionally bestowed with. A fifteenth century Sinhala narrative poem *Kavyasekaraya*, written by Sri Rahula thero of Thotagamuwa (contains advice given by a noble father to his daughter before marriage) still continues to be included in the school curriculum, reiterating women's social reproductive role. Some of the advice proffered to women is to:

Be like a servant to your husband, his parents and his kinsmen; do not give anything away even to your own children, without your husband's consent; seek out your husband's desire in food and see that he is constantly satisfied, feed him and ensure his well-being like a mother.⁵⁹⁵

⁵⁹⁴ Jayawardene, *Feminism and Nationalism*, p. 120 and Jayaweera (ed.) *Women in Post-Independence*, (2002). I do not mean that literacy rate reflects the level of education in a country. Of course literacy and education are two different concepts, but the literacy rate is one of the main determinants that measures social development.

⁵⁹⁵ Jayawardene, *Feminism and Nationalism*, p. 113–14.

This social reproductive ideology, which framed women's thinking and behaviour, was further defined by conferring another responsibility upon women: the national and cultural reproduction of the nation, from the period of British colonial rule and through the nationalist struggles in Sri Lanka. As I mentioned in the introduction, Anagarika Dharmapala was a leading nationalist of the era who made a great impact on the lives of the rising Sinhalese middle class in the early twentieth century. Dharmapala introduced a new Sinhalese Buddhist life style, and bestowed women with a special and rather active role within the domestic sphere.⁵⁹⁶ Housekeeping became a woman's key responsibility. The middle class mother who attended to all the housekeeping and child rearing duties was attributed with a holy status within the Buddhist revivalist ideology; she was considered the 'Buddha at home' (*Gedara Budun*).⁵⁹⁷ Her parental responsibility was emphasised in the nuclear family unit, where the mother played the role of a teacher within the domestic sphere, cultivating social and moral values in children, while the father played a social role in the public sphere by providing for the family.

⁵⁹⁶ "Daily Code for the laity" (In Sinhala *Gihi Dinacharyawa*) a pamphlet published by Anagarika Dharmapala in 1891 was an attempt to civilise the emerging Sinhalese middle class. It provided detailed advice for the laity on general etiquette and dress. The laity was given instructions under twenty-two headings such as, how to behave during meals, how to travel in public transportation, on wearing clean clothes, good toilet habits etc. Out of these, thirty rules were laid down on how women should behave and their duties towards the family. In general these rules give a clear picture of Dharmapala's intention of social reform; he touches upon all the aspects of a laity's life. By 1958, 49,500 copies of the pamphlet had been sold.

⁵⁹⁷ I have pointed out in chapter four how this idea of '*Gedara Budun*' (Buddha at home)—the mother—and *Gedara Pradhaniya* (main person at home)—the father—is internalised through school education in Sri Lanka.

In this context, the health of the family was a prime duty of the wife and mother. As part of women's social reproductive role, Dharmapala advised women to see to the needs of all the members (including the servants) of the house; hygiene was also defined as a key responsibility, in order to ensure the smooth functioning of the home.⁵⁹⁸ This ideology was further emphasised through the school curriculum. The health of the family lay squarely in the hands of women.⁵⁹⁹ Though women in Sri Lanka were taught the importance of health and hygiene, in school, they were not trained to attach the same importance to their own health because, as social reproducers, women were primarily care-givers to the family. Health education was provided to women because of their social reproductive role of providing nutritious food and boiled water for the family, washing the clothes of the family, inculcating hygienic habits among children and keeping the house clean.⁶⁰⁰ The WWC attendees that I interviewed mentioned most of these activities among their daily household chores, which I observed during these interviews. They also expected a girl child to learn these activities. Stressing how important it is to ensure that her children ate nutritious food, forty-three year old Lalani (Kotalawalapura WWC attendee) proudly said:

⁵⁹⁸ According to *Sigalovada Sutta* in *Digha Nikaya*, some advice that Lord Buddha gave regarding noble living, was to take care of the employees and servants. Dharmapala's project is essentially a Buddhist project in modern times. <http://www.accesstoinight.org/tipitaka/dn/dn.31.0.nara.html> (Accessed on 18 November 2012).

⁵⁹⁹ This notion was propagated first by Anagarika Dharmapala in the pamphlet, 'Daily code for the laity' in 1891. Even today, the same ideology transmits through school curricular.

⁶⁰⁰ Bjorkman (1985) argues that women's education in Sri Lanka has improved home hygiene and nutrition practices, thus ensuring reduced infant mortality and prolonged life expectancy. The general understanding is such that even though women hold professional jobs, they should meet their social reproductive role as well.

I still feed my daughter (23 years old) and son (21 years old) while they get dressed to go to work in the morning, if they don't have time to have breakfast. I make it a point that they don't eat junk food. In fact now, neither of them can tolerate fast food, it doesn't agree with their systems.⁶⁰¹

These interviews affirm that a biological and social reproductive role was clearly embedded within the educational and social upbringing of the girl child in Sri Lanka. Discourses on women's bodies are essentially framed around social reproduction, and this has to be taken into account when introducing the new shift in women's health, 'beyond reproduction.'

With this in mind, I will now address the way in which the public health infrastructure—that had been catering to a family planning agenda for more than three decades—was geared to make this shift in Sri Lanka.

'Beyond Reproduction' within Public Health Infrastructure

I did not come across a single divorcee, widow or sterile woman in the WWC registers that both clinics have maintained since 2006. From my interviews with medical professionals attached to the public health sector, it was evident that women are counted and registered within the public health sector in Sri Lanka only when they start receiving ante-natal care at MCH clinics. This means that women become 'legible' in the state records/archive, or enter into official statistics, only through their active reproductive bodies. Because WWCs are placed within the MCH clinic premises, unmarried and sterile women cannot gain access to

⁶⁰¹ Interview with Lalani (WWC attendee), 08 April 2010 at her residence in Kotalawalapura.

them; public health workers are unable to identify them since they are not listed in the MCH registers. Thus, unmarried and sterile women are excluded from this supposedly comprehensive new women's health initiative.⁶⁰² Even though the stated aim of the WWC programme is to 'enhance women's health in Sri Lanka,' by placing WWCs in the MCH clinic premises, its effect was quite the opposite. It marginalised a section of women whose bodies were deemed unworthy of the attention of public health care purely because they were non-reproductive bodies.

Furthermore, divorced women were also excluded from WWCs. During my fieldwork, I learnt that the public perceive the MCH clinic as providing maternal and child health care, often referred to as 'family planning clinics'. Placing WWCs in that setting has resulted in misconceptions. As one of my respondents pointed out, when Kusum, a forty three year old divorcee, tried to go to a WWC with her cousin, her relatives had said that:

People in the village will look at you in a suspicious manner. The MCH clinic is providing family planning service to the community no, so people will wonder why you are there. People will not bother to find out the real reason for your visit to the MCH clinic; instead they will spread unnecessary rumours about you getting family planning treatment at the MCH clinic. So why do you want to invite unnecessary problems?⁶⁰³

In the patriarchal society of Sri Lanka, women's lives are rigidly controlled by social values and norms. Thus Kusum did not visit the WWC for a whole year. She

⁶⁰² Further, adolescent, geriatric and disabled are some of the other categories that are excluded from the women's health programme of Sri Lanka. (*Women's Health Manifesto*, Colombo: SSA, p. 12).

⁶⁰³ Interview with Kusum (WWC attendee), 19 March 2010 at her residence in Kotalawalapura.

attended the Kotalawalapura WWC only after much persuasion by one of her good friends. If a divorcee hesitates to attend a WWC in this context, then unmarried women are even more unlikely to attend lest they arouse suspicion within the community that they are sexually active. Kusum's hesitation to attend a WWC points to the vexed connection between women's bodies, reproduction and the controlling and planning ideology of women's health discourses in Sri Lanka.

After I interviewed Kusum, I questioned the officials about the decision in placing WWCs on MCH clinic premises, referring to the statements made by my respondents. They explained to me that it was economical to have a family planning clinic and a WWC at the same premises, since both clinics use similar equipment (such as speculums) and the same resources.⁶⁰⁴ One official noted: 'Since family planning clinics are well established across the country, it is cost effective (in terms of getting water and electricity) to utilise the same premises rather than establishing a separate clinic.'⁶⁰⁵ I was not surprised by this answer. In hindsight, I realised that placing WWCs on MCH premises provided an ideal context in which the introduction of a paradigm shift in women's health could be lost in the stereotypical 'lack of resources' story. It is evident that the state (in this case the FHB) was concerned only with *somehow* implementing the WWC

⁶⁰⁴ Interview with the National Programme Manager Gender and Women's Health at the FHB, 26 March 2010 at the FHB, Colombo and a junior medical doctor working at the WWC division of the FHB.

⁶⁰⁵ Interview with a lecturer at the Department of Community Medicine, Faculty of Medicine, University of Colombo who worked with FHB on initiating WWC programme, 30 March 2010 in his office at the Faculty of Medicine, University of Colombo.

programme, rather than realising the new ideology of women's health 'beyond reproduction' through WWCs.

These interviews affirm that there is a clear disconnect both at the policy-making and institutional levels. Having closely examined this problem, it is clear that both these disconnections stem from reading the discourses on women's health and women's bodies as separate entities, territories and epistemes by disregarding the mutual inclusiveness of the two.

The second and third characteristics that the architects of the WWC programme articulated were that WWCs are to screen healthy bodies for common non-communicable diseases, and that WWCs are for healthy women. Since they are interlinked, I will explore these two articulations together.

WWCs are to Screen Healthy Bodies

The WWC programme proposes a screening and monitoring process of healthy, post-reproductive women's bodies as part of preventive health care.⁶⁰⁶ Circulars clearly set out the idea that WWCs are for 'healthy' women by recommending WWC tests 'for any woman over 35 years.'⁶⁰⁷ Public Health Midwives (PHM) are advised to educate and inform women in the area, with the help of field officers.⁶⁰⁸ Screening is a new concept to the public health sector in Sri Lanka. Both Attidiya and Kotalawalapura PHMs expressed difficulty in articulating the idea of screening

⁶⁰⁶ Age 35 is regarded as the upper limit of bearing children in Sri Lanka.

⁶⁰⁷ Clause (2) of the Guidelines for implementation of the WWC programme dated 14th July 1999, issued by the FHB, Colombo.

⁶⁰⁸ Guideline (5) of the General Circular No. 1926 dated 19th August 1996.

‘healthy women’ for common, non-communicable diseases. One of the PHMs (Anusha from Attidiya) said that she could not convince her own mother, who is fifty-five years old, to undergo WWC tests. Her mother was embarrassed to show private parts of her body to anybody, now that she was in her old age. In addition, her mother had said: ‘It is not worth spending money on me even if I have a serious illness such as cancer, because I have lived my life, now it is your turn to live a good life.’⁶⁰⁹ Another PHM, Pushpa, noted that her mother who is fifty years old had said:

It is a sin to let my unclean parts [*kili*] be examined by a male doctor. He [referring to the MOH] must be my son’s age. By doing those tests [referring to Pap smear test] I will prolong my sinful life and will definitely be a woman in my next birth also.⁶¹⁰

Even though Pushpa tried to explain that the doctor would be examining for a particular health condition and that he would not perceive it as an ‘unclean part’ since he is a professional, she failed to convince her mother. Clearly, if the MOH is a male, the older women find it difficult to attend the WWC. According to the cultural understanding of women’s bodies in Sri Lanka, all forms of cervical discharges are understood to be *kili*, meaning unclean/dirty.⁶¹¹ Older women hesitate to allow the Pap smear test to be performed by a male doctor because they think that it is a sin to let a male doctor examine their body, particularly the vaginal area. In Sri Lanka, Buddhists generally believe that to be born male is

⁶⁰⁹ Interview with Anusha (PHM) Attidiya, 23 March 2010.

⁶¹⁰ Interview with Pushpa (PHM) Attidiya, 23 March 2010.

⁶¹¹ During menstruation women do not step into a Kovil. Even though god worshipping is historically a Hindu tradition, today it is a Buddhist practice as well.

more fortunate than being born female. They also believe in rebirth, the form of which depends on the *karma* done in previous incarnations.⁶¹² Women aspire to be born male in their next birth by being more respectful towards men in their current lives. By allowing a male doctor to examine her body, Pushpa's mother thought that she would accrue more sins in her present life and would be born a female in her next birth as well. Unlike the norm today, these women were helped in their deliveries by midwives, and now they feel uncomfortable and considered a sin to be examined the vaginal area by a male doctor.

Further, older women have a very different view of the preventive tests that are conducted at WWCs because preventive tests or body check-ups are unfamiliar concepts to them. Screening of healthy bodies is an innovative idea in Sri Lanka because it challenges previously held notions of health and women's bodies which are interconnected with traditional medical practices of Ayurvedic, Unani and Siddha systems, religion, and women's position in the patriarchal household. Anthropologists who study notions of illness and sickness in colonial contexts perceive medicine to be a part of culture.⁶¹³ Interpretations of disease/illness and ailments originate from culture, because people perceive their

⁶¹² See Kitsiri Malalgoda, *Buddhism in Sinhalese Society 1750-1900: A Study of Religious Revival and Change*, University of California Press, 1976, R. F. Gombrich, R. Gombrich and G. Obeyesekere, *Buddhism Transformed: Religious Change in Sri Lanka*, Princeton University Press, 1988, S.J. Tambiah, *Buddhism Betrayed?: Religion, Politics and Violence in Sri Lanka*, University of Chicago Press, 1992, S. Wickremaratne, *Buddha in Sri Lanka: Remembered Yesterdays*, Albany, State University of New York Press, 2006, D.A. Premakumara de Silva, 'Anthropology of Sinhala Buddhism', *Contemporary Buddhism An International Journal*, 7:2(Nov. 2006), J. Uyangoda, *Religion in Context: Buddhism and Socio-Political Change in Sri Lanka*, Colombo, SSA, 2007 for a detailed anthropological analysis of different ritual and worshipping practices and beliefs of Buddhists in Sri Lanka.

⁶¹³ Kleinman, A., *Writing at the Margin: Discourse between Anthropology and Medicine*. Berkeley, Los Angeles and California, University of California Press, 1995, p. 8.

bodies as part of culture and bodies are placed within culture. Though Western medicine, as a rational, scientific and institutionalised system, has all the necessary attributes for widespread acceptance, there are certain elements (especially with regards to women's bodies) which Sri Lankans constantly relate to culture but make no sense within science. For example, chanting the *angulimala piritha* before a confinement in order to strengthen the pregnant woman and enable a smooth delivery is one such belief and practice.⁶¹⁴

According to the Ayurvedic medical system, sickness is a result of an imbalance of certain bodily components, referred to as *Thridosha*: *Vatha* (wind), *pitha* (bile) and *sema* (Phlegm). In order to maintain the equilibrium of these *doshas*, people are recommended to eat healthy food, engage in physical exercise and practice certain bodily regulations. These bodily regulations and food restrictions constitute the preventive aspects of the Ayurvedic medical system. Thus, people seek medical care only when they can no longer manage their bodies through this framework, and accept that they are sick. During my conversations with older women (mainly my interviewees' mothers or aunts) it was evident that traditional concepts of the body precluded notions that healthy bodies should be screened.

To be healthy meant not to be associated with clinics and medical care, in the reckoning of the lower middle-class women whom I interviewed. They were

⁶¹⁴ According to Buddhist *Jathaka Stories*, Angulimala thero had helped a pregnant woman during her delivery, so when the delivery date draws near it is a practice in Buddhist households today to invite monks to chant *Angulimala Piritha*.

proud to say that they had not paid a visit to any medical setting during the last couple of years. During my conversations with the fifty-nine year old mother of one of my respondents, Wasana, the former said:

My husband and I have a good understanding about our bodies. Both of us do not seek medical help unless it is really necessary. Our life style and eating habits have given us good health and we listen to the rhythm of our bodies...Rhythm is what the body needs, for example, if I don't feel like having a bath today, I refrain from having a bath and if I feel like lying on the bed for some time I do so, because my body needs it. Now-a-days, these children (pointing to Wasana) wash their hair just because they want to go out in the evening, without actually listening to what the body says. I think such practices cause unnecessary problems and health hazards. I think I haven't visited a doctor for more than 3 years now (A proud smile crossed her lips).⁶¹⁵

During the course of my research, I came across two distinct connotations of the concept of 'healthiness'. WWCs are introduced for 'healthy' women as a preventive measure, in order to maintain their good health, while, for many of my respondents, 'healthiness' meant keeping away from medical settings. During my fieldwork, I observed that people in general, and women in particular, seek medical help or advice only if they are evidently suffering from an ailment. These women try a range of home remedies prior to seeking medical help. For example, if they have a cough and cold they take *Koththamalli*, *pas panguwa* or *peyawa*, (all consist of a decoction of herbs such as coriander seeds, *pathpadagam*, ginger, black pepper, *Venivel* and *Katuwelbatu*), for aches and pains in the knees and back they apply *Siddhalepa* (a herbal balm) and take *Panadol* (Paracetamol) or drink boiled

⁶¹⁵ Interview with Wasana's mother at her residence in Kotalawalapura, 8 April 2010. Wasana is my interviewee (WWC attendee).

garlic water. If, after two to three days of such treatment, the ailment still persists, they seek medical help, most often from the nearby dispensary or government hospital at Kalubowila. However, WWCs are designed not for sick but healthy women. Why should a woman go to a clinic or seek medical advice when she is feeling fine and healthy? There is a disconnect between the preventive approach of WWCs, such as screening and periodic body check-ups, and the general understanding of healthiness among the lower middle class women who largely use public health sector services in Sri Lanka.

Further, according to popular belief, cancer (breast cancer and cervical cancer are two of the conditions detected early through WWCs) is associated with '*Karma*' or '*Karuma leda*,' which means that these sicknesses cannot be avoided since they occur either because of the sins committed by the afflicted in their previous births or it is God's will. During my fieldwork I encountered such beliefs in Buddhist and Muslim families. According to some of the Buddhists that I interviewed, if a person had committed a sinful *karma* in a previous birth, they must repay it by accepting the consequence, such as cancer.

When I asked forty-three year old Hareena (a Muslim WWC attendee in Attidiya) why her sisters and sisters-in-law had not attended the WWC, she said:

Unlike myself, they are devoted Muslims, so they will never go against God's wish. They believe that if a person has to suffer from a sickness, however much he or she tries, it is impossible to get away from it. You have to undergo the suffering.

In addition, she admitted that her views had changed radically in comparison to that of her own family members, due to her exposure through her job at the Open University at Nawala, where she associated with people from diverse backgrounds.⁶¹⁶

Moreover, I also met women, (mostly older women) who vehemently believe that there was no way they could be afflicted with cancer: the *Karuma leda*.⁶¹⁷ They believe that as they have led a just and peaceful life, there is no need for them to undergo WWC tests since they are certain that they will not suffer the illnesses screened for at the WWC. These women have a specific understanding, perception and belief about themselves and their bodies, which is closely associated with their culture, religion and life experiences. Unlike other clinics—such as antenatal and post-natal that address a specific condition—the WWC addresses women’s health in a holistic manner. Thus, it is important that the designers of national programmes consider these women’s specific language, beliefs, culture and perceptions of the body, instead of blindly following an international model constructed to eliminate non-communicable diseases. My interviews clearly point to a disconnect between the concepts promoted by the WWC programme, the state’s framing of women’s bodies in the 1990s, and cultural understandings of women’s bodies.

⁶¹⁶ She has left the job after the third child was born and now runs a grocery shop together with her husband.

⁶¹⁷ Mothers of my respondents, with whom I had a chat during my field visits.

I will now consider the PRH policy of 1998, (another policy initiated as a consequence of the ICPD Cairo in 1994) in order to illustrate the inability of the state to conceptualise the shift in women's health—from controlled and planned women's health to reproductive health and rights. I argue that this inability occurred because the PRH policy was too inclined towards demographic targets. A Malthusian focus on population control emerged in new avatars, preventing a reproductive health and rights approach from becoming firmly established within women's health discourses.

Population and Reproductive Health (PRH) Policy - 1998

In tracing the history of population policy in Sri Lanka (in Chapter One), I have shown that different nuances of meaning were attached to the population rhetoric of Sri Lanka at various moments in the history of post-independence Sri Lanka. The need for formulating a population policy was quite clearly stated in almost all the literature that I came across, although I did not find a concrete policy document until 1998: The Population and Reproductive Health Policy.⁶¹⁸ The PRH policy was initiated and supported by the Population Division of the Ministry of Health, and formulated within 12 months by a National Task Force. The PRH policy was approved by the National Health Council on 23 December 1997 and by the Cabinet on 27 August 1998.⁶¹⁹ This is Sri Lanka's only policy document on

⁶¹⁸ Despite the success story of Sri Lanka in curbing population growth rates.

⁶¹⁹ *Population and Reproductive Health Policy 1998*, Ministry of Health and Indigenous Medicine, Sri Lanka, p. 37 and Abeykoon, 'ICPD 15 Years On: Sri Lanka's Participation', p. 8.

population, and it was formulated as a direct consequence of the ICPD. Therefore, it should clearly demarcate the shift (from family planning to reproductive health and rights) in women's health proposed at the ICPD. However, the PRH policy, like the WWC programme, did not adopt the concept of reproductive rights. As I pointed out above, human rights were deeply undermined in 1990s Sri Lanka, and in that context, there was no space for a reproductive rights discourse to germinate. Furthermore, the PRH policy was preoccupied with demographic goals, such as stabilising the size of the population by at least the middle of the next century.⁶²⁰ In this context, the introduction of reproductive rights did not seem imperative.

Indeed, the PRH policy has adopted the meaning of reproductive health *exactly* (word for word) as it is outlined in the ICPD Programme of Action, with a few changes to suit the Sri Lankan context. According to the ICPD Programme of Action, reproductive health implies

that *people* are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide *if, when and how often to do so* (emphasis mine).

(Chapter VII, Paragraph 7.2, Programme of Action, ICPD, 1994)⁶²¹

The PRH policy document replaced the 'people' in the ICPD Programme of Action with 'couples', and 'freedom to decide if, when and how often to do so' with 'freedom to decide responsibly on the number of children they may have.' It thus states:

⁶²⁰ *Population and Reproductive Health Policy 1998*, p. 27.

⁶²¹ <http://www.un.org/popin/icpd/conference/offeng/poa.html> (Accessed on 20 June 2011.)

Reproductive health therefore implies that *couples* are able to have a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide *responsibly on the number of children they may have* (emphasis mine).

(Population and Reproductive Health Policy 1998)

These changes illustrate how influential Malthusian thinking was in the PRH policy, even at the supposed point of departure from a 'controlled and planned' programme to an emancipated women's health approach.

Instead of 'People', 'Couples' were Adopted

Since children are typically conceived within the setting of a heterosexual nuclear family in Sri Lanka, the term 'couple' is used to denote parents (husband and wife).

De Silva reminds us that single mothers and children born out of wedlock are very rare in Sri Lanka; thus, the PRH policy uses the term 'couple' (meaning husband and wife) in place of the term 'people' used in the ICPD Programme of Action.⁶²²

Furthermore, the discourses on lesbian, gay, bisexual and transgender (LGBT) rights are limited to a very exclusive niche group in Sri Lanka. Sri Lanka refused to sign the December 2008 UN Declaration that urged member-states to de-criminalise homosexuality. Homosexuality is a criminal offence under Section 365 and 365a of the Sri Lankan Penal Code.⁶²³ Even today, despite substantial pressure by the LGBT community in Sri Lanka, the state has refused to de-criminalise homosexuality. This demonstrates the state's inability to accommodate non-

⁶²² Indralal de Silva, 'Correlates of Marital Postponement in Sri Lanka', *The Journal of Family Welfare*, 46: 2(October 2000), p. 42.

⁶²³ http://www.glapn.org/sodomylaws/world/sri_lanka/sri_lanka.htm (Accessed on 21 May 2012).

heterosexual forms of sexual orientation, and reveals the heterosexual nature of the state's ideology.⁶²⁴ Given these facts, the 'couples' mentioned in the PRH policy are clearly those in heterosexual relationships.

By stating that 'couples are able to have a satisfying and safe sex life,' the PRH policy addresses only heterosexual couples who are capable of bearing children. The PRH does not accommodate other forms of sexuality such as homosexuality and bisexuality, and excludes non-procreative bodies such as infertile or unmarried women, because these groups do not impact the population growth rate. Not only is their sexuality muted, but also their right to health care is ignored within the public health care system by its exclusion from the PRH policy.

Instead of 'freedom to decide', freedom to 'decide responsibly' was Adopted

What does the PRH policy mean by 'responsibly'? For whom are they responsible? As responsible citizens of the country, heterosexual couples are expected to reproduce according to their social and economic status in society. Referring to the post-ICPD Indian experience, Simon-Kumar says that neo-liberal market forces convert citizens into 'ideological subjects' and makes them believe that their relationship with the state is less about what 'rights' they can claim from the state

⁶²⁴ India de-criminalised private, consensual sex between adults of the same sex on 2 July 2010. Sri Lanka has still not taken any affirmative action in this regard. For the current status of LGBT rights in Sri Lanka see <http://groundviews.org/2010/07/07/celebrating-a-lesbian-gay-bisexual-transgender-inquiring-and-queer-sri-lanka/> (Accessed on 21 May 2012).

than what ‘obligations/responsibilities’ they owe the state.⁶²⁵ In the Sri Lankan case, I argue that it was not neo-liberal market forces that influenced the formulation of PRH policy but deep-rooted state welfare policies in Sri Lanka. As I have pointed out above, because the State provides free health care to the public, state officials fail to see health as a right of the people; they continue to treat people as beneficiaries of the public health care system and to hold citizens responsible for the health care they are given. Through logos and other published material, the state holds women responsible for the number of children they produce. Even though no number is explicitly mentioned (unlike, for example, the one child policy in China), the two child family norm was nevertheless established in Sri Lanka by the late 1980s through the dynamic family planning campaign under a former secretary of the Ministry of Plan Implementation which I have discussed in detail in Chapters One and Two.

Moreover, by placing the term ‘decide’ parallel to ‘responsibly’, the empowering effect implied by the term ‘decide’ is diminished. Instead, the couple is bestowed with a responsibility towards the nation and the state, which urges them towards a two child family norm. This process is reminiscent of the film “In your hands”, produced by the FPA in 1964, and the slogan ‘*punchi pavula raththaran*’ (a small family is golden) used in the 1980s to convey the message that having a small family is part of the responsibility of every citizen to further the

⁶²⁵ Rachel Simon-Kumar, ‘Neo-liberal Development and Reproductive Health in India: The Making of the Personal and the Political’ in *Indian Journal of Gender Studies*, 14:3 (2007), p. 367.

development cause of the nation.⁶²⁶ Therefore, the sinews of the controlling and planning ideology of women's health are embedded in the PRH policy of 1998. Although the ICPD promoted women's empowerment through reproductive rights, the Sri Lankan state was unable to capture the 'reproductive rights' ideology in its PRH policy of the 1990s. Furthermore, the major violations of human rights during this period prevented the state from addressing the reproductive rights of women.

Instead of 'if, when and how often to do so', 'the number of children they may have' was Adopted

The PRH policy suggests that couples could decide responsibly the number of children they may have, not the number of children they 'want' to have. The whole notion of freedom that was proposed in the statement 'if, when and how often to do so' in the ICPD Programme of Action is negated by its substitution for the 'number of children they may have' in the PRH policy. Moreover, it implies that the number is in fact decided for the couple by some external force, rather than by the couple themselves. The 'number' mentioned in the PRH policy is itself crucial, because the ICPD explicitly rejected numbers and targets; it was a shift from 'an approach based on demographic targets to a comprehensive reproductive health approach,' and from "numerical quotas to informed choices."⁶²⁷ By stating that couples should 'decide *responsibly on the number of children they may have*'

⁶²⁶ *Annual Report of the Family Planning Association 1963-64*, Colombo, FPA, p. 10.

⁶²⁷ Petchesky, *Global Prescriptions*, p. 35 and Simon-Kumar, *'Marketing' Reproduction?*, p. 6.

the PRH policy hints at the implicit coercion of the ‘controlled and planned’ ideology of the pre-ICPD era. Moreover, it confirms that, to use Hodges’ phrase, ‘Malthus is forever’ haunting the actions of the policy makers of the PRH policy in Sri Lanka.⁶²⁸

Numbers and spacing of children is further stressed in goals one and two of the PRH policy document:

Goal 1 Strategies – Improve quality of service delivery to enable couples to decide freely and responsibly the number and spacing of their children.

Goal 2 Strategies – Promote family planning so that pregnancies do not take place too early in life or too late in life, are appropriately spaced and are not too many.⁶²⁹

Goal 2 echoes the FPA slogan of the 1980s, ‘not too many, not too soon, not too early, not too late.’⁶³⁰ Even though the PRH policy attempts to advocate reproductive health, it nevertheless implicitly signals the number of children a family should have, and how important it is to space these children in order to produce a healthy future generation. Number and spacing were the linchpins of the Sri Lankan family planning programme in the 1980s. However, it seems that the same quantitative aspect of population resonates in different avatars well into the late 1990s, not least through the PRH policy.

⁶²⁸ By reviewing Hartmann, Connelly, Halfon, Rao and Simon-Kumar, Hodges points out how Malthus is ever so present in framing of population policies in the third world. See Hodges, ‘Review Article: Malthus is Forever (2010).

⁶²⁹ *Population and Reproductive Health Policy 1998*, Ministry of Health and Indigenous Medicine, Sri Lanka, p. 29-30.

⁶³⁰ *Annual Report of Family Planning Association 1980*, Colombo, FPA, 1981, p. 10.

As Hartmann correctly points out, the ICPD has taken out the ‘hard core coercion’ but brought back the ‘soft sell strategy’.⁶³¹ This is clearly manifested in the family planning incentives offered in Sri Lanka from the 1980s to the present day. Despite the PRH policy, the FHB still makes a payment for sterilisation: LKR 500 (GBP 2.39) for the client and LKR 65 (GBP 0.31) to the medical doctor and PHM.⁶³² This amount has been consistent from the 1980s. Furthermore, addressing the rise in total fertility rate (2.3 according to Sri Lankan Demographic and Housing Survey 2006/2007) from November 2010, the Ministry of Health has decided to distribute oral contraceptive pills and condoms free of charge.⁶³³ Both these decisions are not only about a ‘soft sell strategy’, but also exemplify the elision of reproductive rights. By offering an ‘out of pocket allowance’ to the client and the medical staff and—to borrow a phrase from a government minister in the 1980s—‘doling out’ pills and condoms through PHMs, the government exercises indirect coercion, which in turn denies clients (mostly women) their reproductive rights.

Even though the PRH policy was designed as a consequence of the ICPD, it failed to address the core concept of the ICPD: reproductive health and rights free from any form of direct or indirect coercion. Thus the PRH policy remains yet another half-realised dream of a post-ICPD women’s health initiative in Sri Lanka.

⁶³¹ Hartman, *Reproductive Rights and Wrongs*, p. 153.

⁶³² General Circular No. 01-09/2007 on ‘Payment for female/male sterilizations’ of the FHB, Colombo, issued on 3 April 2007.

⁶³³ General Circular No. 01-39/2010 on ‘Removal of fee for Oral Contraceptive Pills (OCP) & Condoms’ of the Ministry of Health, Colombo, issued on 2 November 2010.

Concluding Thoughts

The two most challenging women's health policies of the post-Cairo era in Sri Lanka were the WWC programme of 1996 and the PRH policy of 1998. The shift in women's health proposed at the ICPD—from family planning to reproductive health and rights—was not fully addressed by either of these policies. According to my reading of these policies, and my interviews with the architects, implementers and users of WWCs, I attribute this shortcoming or failure to the inability of the state to read women's health discourses alongside the discourses on women's bodies, in the 1990s. Since these two discourses were never read together or laid side-by-side in Sri Lanka, the new shift in women's health became a half-realised dream within the women's health discourses of post-independence Sri Lanka, just as in other parts of the world.

Conclusion

At the outset of this thesis I stated that my intention was to write a critical history of women's health in modern Sri Lanka. In fact Sri Lanka's women's health statistics are remarkable compared to the region. Internationally renowned demographers, development economists and public health experts hailed Sri Lanka as a 'development model' by the 1970s for her low fertility and mortality rates, high female literacy levels, women's empowerment and a sound public health care service. Since population is seen within the development discourse as one of the main determinants of development, women's health emerged as the main development indicator within the state building project of independent Sri Lanka. Thus women's health served as a linchpin to the attainment of this 'success story'. Although development experts, economists and demographers have been comfortable with this 'success story' based on statistics and indicators, as a woman historian with a critical mind I found it problematic. Because the woman's body is the ground in which women's health policies are implemented, I believe her corporeal experiences and the related discourses on the woman's body play a significant role in women's health. In fact, I was interested in exploring what these statistics did not and still do not say. I found Foucault's approach towards history writing as the best method to pursue this task: by 'disturbing and questioning the tranquillity' with which this 'success story' is accepted and has become common sense knowledge in Sri Lanka.

In critical history writing ‘success stories’ are considered problematic, as they are built on pillars of subjugation and silence. As historians we know that emerging of one story means that there are several other simultaneous subjugated stories which were not given adequate attention in traditional history writing. My interest lie in these subjugated stories, because they elucidate broader insight to the larger picture and also how power relations work between various actors in society. With this aim in mind I have approached the woman’s body through her corporeal experiences and discourses on the woman’s body which were framed through nationalist discourses during the colonial period of Sri Lanka. I placed both ‘women’s health’ discourses and discourses on ‘woman’s body’ within a unified crucial analytical framework to bring out these subjugated stories. By doing so I was able to provide a wider lens to comprehend women’s health and this in turn became the basis of my writing of a critical history of women’s health in post independence Sri Lanka. My study showed that women’s health statistics have become so dominant in explaining this ‘success’ that they have managed to mask the processes that were muting and silencing women’s bodies—both their individual and collective corporeal experiences.

Main Contributions

As a piece of original research my thesis made both conceptual and analytical contributions to the area of women’s health in Sri Lanka. By surfacing subjugated stories of woman’s body I was able to provide a different reading to the twentieth-

century women's health in Sri Lanka. By unearthing primary sources and reading the archival material against the grain I was able to provide a new analytical framework for women's health in Sri Lanka.

Conceptual Contribution

Instead of reading women's health through statistics, I have attempted to conceptualise women's health in post independence Sri Lanka through subjugated stories of women's corporeal experiences and discourses on woman's body. I deployed multiple methods such as archival research, in-depth interviews and oral histories to explore these subjugated stories. By doing so I was able to place discourses of women's health and discourses of woman's body in a single analytical framework.

Women's health discourse in Sri Lanka is predominantly a territory confined to policy makers, medical professionals, demographers and economists. In contrast, the discourses on woman's body seem to be a territory largely confined to attentions of feminist social scientists. These two groups in Sri Lanka did not dare to leave their epistemic province. As a historian I trespassed these boundaries between women's health and women's bodies. It was indeed a challenging experience to trespass into others' epistemes. However, it gave me the opportunity to understand how; global population debates are being played out in Third World countries, international funding for population control works and power works in the health sector in Sri Lanka, academia and policy makers work

within broader framework of global health. Because I permeated from medical faculty of Colombo University to Indigenous Medical Faculty to FPA (a NGO) to FHB and to public health sector workers at the grass roots level to women recipients of health policy in Sri Lanka. Each of these institutions and people within them shared with me number of different stories. Of course these stories did not relate a linear sequential order of events. Sometimes they related opaque and contradictory stories and at other times they relate very similar stories. By listening to them very carefully and referring to historical evidence from numerous archives I was able to bring out the subjugated stories of women's health. I earnestly hope that the new approach that I propose – to place women's health discourse and discourses of woman's body in a single analytical framework - would help to do justice to women's health by having a holistic inquiry in future.

Further, after ending a twenty-six year ethnic conflict, I believe that this is the right moment to release woman's body from nation building project of post-independence Sri Lanka and empower them by granting reproductive rights. This is the right moment to challenge the national responsibilities that the woman's body has carried so far and to create a new empowered individual human body for women.

The chapter about Pill trials in Ceylon is a new contribution/addition not only to the local understanding of the introduction of the Pill to Ceylon but to the global Pill history. It analysed how global Pill trials were conducted in South Asia and also why Ceylon became part of it in 1961. Through the correspondence that I

have unearthed in the US between Pincus, pioneers of family planning and Chinnatamby I showed how Ceylon entered into a modernisation discourse through Pill trials. As Chinnatamby's personal records were not available in Sri Lanka my investigation and analysis into her personal correspondence with pioneers in contraception was a noteworthy attempt to introduce the discipline of history of medicine to Sri Lanka. My analysis of politics and funding of clinical experiments of the Pill gave a broader picture of the Third World contribution to a pioneering modern scientific product. Further my investigation to the Pill trials in Ceylon gives a new turn to family planning and women's health history writing in Sri Lanka. Because, so far women's health projected a 'success story', whereas now by taking discourses on woman's body into the same analytical framework I created new avenues to write women's health history in Sri Lanka by challenging linear history writing tradition.

Further through my analysis of the programme on social marketing of contraceptives in 1974 I showed how women's health and bodies became the ground in which market forces (*Mithuri*) replaced ethnic forces (*vanda beheth/pethi*) in Sri Lanka. It further established the importance of bringing both women's health discourse and discourses on woman's body into a unified analytical framework.

I have contributed to women's health history writing in post independence Sri Lanka by introducing new analytical categories such as 'beyond reproduction'. Analysing the broader economic, social and political milieu in the 1990s I showed

how the state deployed women's health and bodies to maintain the 'model' status of South Asia.

With the above mentioned approaches and analysis this thesis made an earnest effort to provide a different reading to Sri Lanka's women's health 'model status' which is essentially different from readings of history of family planning, development and population control.

Analytical Contribution

According to my analysis of the public health welfare policy of Sri Lanka, the state makes women mere beneficiaries of women's health creating a certain paternal tutelage. As mentioned at the beginning within the state building process of post independence Sri Lanka women's health became the linchpin of state's strategy. In the aim of keeping population growth rate under control the state regulated the reproductive body of woman by implementing a welfare policy for women's health. On the one hand this prolonged welfare approach towards women's health has made women dependent of the state. On the other hand the state has conveniently ignored that health is a human right and a responsibility of the state towards its citizens. Thus the state provided and still provides health care to women beneficiaries, not to women citizens. My research especially through the interviews that I had with policy makers and recipients of public health policy it became evident that this dependent mentality of women and state's inability to regard women as citizens of the state has heightened to such an extent of paternal

tutelage in Sri Lanka. As a consequence, the state treats women as mere beneficiaries of public healthcare, further disempowering them of their right to healthcare and their own bodies.

The state's deployment of woman's body in nation building in the 1950s, economic development in the 1980s and in safeguarding the state in times of intense conflict in the 1990s further tightened state's grip on woman's body. This in turn became a burden on her biological and social reproductive role disallowing her to think about her body 'beyond reproduction'. When the ICPD proposed to conceptualise women's health within reproductive health and rights framework in 1994, the state could not possibly do so due to these above mentioned tight grip that the state had on woman's body. Through a careful reading of post ICPD health policies (WWC policy and PRH policy), in-depth interviews with WWC policy makers and attendees of WWCs I have shown that Sri Lanka was able to implement the reproductive health component of the ICPD framework but, had failed to address reproductive rights component. The term 'reproductive rights' was not mentioned in any of the WWC policy documents. Thus ICPD became a half realised dream in Sri Lanka and this in turn made Sri Lanka depart from the long held women's health 'success story' by the mid 1990s.

In fact I have not only challenged the women's health 'success story' by bringing forth the other stories of woman's body, but have proved how Sri Lanka failed to uphold its success story by the mid 1990s.

Limitations of the Study

Time is a deciding factor in conducting research. It is not possible to complete research without facing a number of limitations. These limitations are mostly due to not having enough time to engage with sub-stories that we encounter in the long and arduous research journey. Mine was no exception.

The biggest limitation that I encountered in my research was not being able to represent or bring out other minority ethnic ideologies (Tamil, Muslim and Burger) about women's health and body. I have only concentrated on the Sinhalese Buddhist ideology which is generally the hegemonic state ideology of the state. Even though Sri Lanka is comprised of a heterogeneous community, it claims a Sinhalese Buddhist state of 2500 years of written history. Thus the hegemonic state ideology is essentially a Sinhalese Buddhist one. Due to time constraints and also due to my language inability I had to limit my research to the Sinhalese Buddhist ideology of the state. By saying so I do not mean that stories of minority groups are insignificant when attempting to write a comprehensive history of women's health in post-independence Sri Lanka. In fact these minority stories are 'subjugated stories' of the grand narrative of women's health in Sri Lanka.

It was not only the time factor, but also the political situation in the country (post conflict situation) that disallowed me to explore women's health and body discourses in Tamil speaking areas of the country such as Jaffna and Batticaloa (North and East regions of the country). Sri Lanka was able to bring

down the population growth rate to replacement level despite the ethnic war which lasted for twenty-six years. During my informal conversations with the director of the resource centre of the FPA I learnt that the LTTE did not interrupt or interfere with the FPA work in the war torn areas right throughout the war. Investigation into how women perceived their health and bodies in their temporary homes (refugee camps) would essentially provide new stories, which are essential in writing a comprehensive history of women's health in modern Sri Lanka. But when I inquired of a number of academics working on Tamil militant women they said that it is too early to dig into such a matter as women's health, until these women resume their normal lives in their permanent dwellings.

Future Research

By placing discourses on women's health and woman's body at the same table my thesis proposed a new approach for women's health research. This is significant as history of medicine so far is an unknown discipline in Sri Lanka. During my research I came across two particularly intriguing future research possibilities. First, the impact of the market forces on health sector of independent Sri Lanka. Even though this has been looked at by health economists in terms of statistics and numbers, the impact of the market on public health as social welfare and health as a human right is yet to be explored.

Today the health sector of Sri Lanka is getting privatised in a rapid pace. Thus it is time to revisit the health sector of Sri Lanka to see how different actors

(first the state and now the market) try to take reins of women's health and the implications of it. Further as a post conflict state Sri Lanka is facing a number of novel women's health concerns such as gender based violence, reproductive rights and abortion legalisation to think about. Having achieved replacement level fertility and peace after 26 years of conflict is there a need for the state to have a tight grip on women's reproductive bodies any more? Is woman's body free now from the state building and nation building obligations to exert the full meaning of reproductive rights? These are some future research problems that need to be explored by researchers willing to disturb the 'tranquillity' with which Sri Lanka's women's health 'success story' is accepted.

Second, the role that midwives played and still play in creating Sri Lanka's 'model' health statistics. Even though the public health sector today perceives midwives as the avant garde of the 'controlled and planned' women's health programme in Sri Lanka due to their dynamic role in achieving impressive women's health statistics, I see them more as enumerators of a state 'legibility' project. Through their endless record keeping activities, they create a detailed 'map' of women and child populations in each community which enables implementation of population control programmes of a social engineering nature. In other words, state deployed midwives make population growth patterns 'legible' to the state as well as to international funding bodies such as the Swedish International Development Agency (SIDA), International Planned Parenthood Federation (IPPF) and United Nations Population Fund (UNFPA). Thus I feel it is

time to write a critical history of midwifery in Sri Lanka which has not yet been explored.

Appendix

List of Interviews Conducted

Name	Occupation	Key informants/i interviewees	Date and Location of the Interview	Language spoken in Interview
Chairman of the women's Research Committee at the Sri Lanka Medical Association		Key informant	Different occasions over the past 6 years at the Faculty of medicine, Uni. Of Colombo	English
Former Medical Director of the FPA		Key Informant	16 Feb. 2010 at her residence in Colombo	English
Retired Secretary to the Ministry of Plan Implementation		Key Informant	7 Aug. 2011 at his office in Colombo	English and Sinhala
Former Director of the Population Division of the FHB		Key Informant	10 Aug. 2011 at his office in the Institute for Health Policy in Colombo	English
First Executive Director of the FPA		Key Informant	21 Dec. 2009 at his residence in Rajagiriya	English
Vida	Retired Teacher	Interviewee	14 June 2010 at an Orphanage in Wellawatte	English and Sinhala
Jaya	Retired Teacher	Interviewee	5 July 2010 at her residence in Kohuwala	English and Sinhala
Perera	Retired Teacher	Interviewee	14 July 2010 at her residence in Piliyandala	English and Sinhala
Dhana	Retired Teacher	Interviewee	24 July 2010 at her residence in Maharagama	English
Retired Deputy Minister of Health		Key Informant	3 Nov. 2010 at her residence in Colombo 7	English
Former Dean, Faculty of Medicine, University of Colombo		Key Informant	9 June 2010 at his office in Medical Faculty, University of Colombo	English
Sita	FTZ worker in Katunayake	Interviewee	18 Sep. 2010 at her boarding place in Katunayake	Sinhala
Rekha	FTZ worker in Katunayake	Interviewee	25 Sep. 2010 at her boarding place in Katunayake	Sinhala
Devi	Migrant	Interviewee	1 Apr. 2010 at her	Sinhala

	worker		residence in Rajagiriya	
Sumana	Migrant worker	Interviewee	10 Dec. 2010 at my place in Kotte	Sinhala
National Programme Manager, Gender and Women's Health at FHB		Key Informant	26 Mar. 2010 at her office in FHB	English and Sinhala
WWC Programme Director of the UNFPA		Key Informant	17 Aug. 2011 at the UNFPA Colombo office	English
Lecturer, Faculty of Medicine, University of Colombo (Contributor to the Handbook on WWC)		Key Informant	30 Mar. 2010 at the Medical Faculty, University of Colombo	English and Sinhala
Lalani	WWC attendee	Interviewee	8 Apr. 2010 at her residence in Kotalawalapura	Sinhala
Kusum	WWC attendee	Interviewee	19 Mar. 2010 at her residence in Kotalawalapura	Sinhala
Junior Medical Officer at WWC division at FHB		Key Informant	26 Mar. 2010 at FHB	English and Sinhala
Anusha	Public Health Midwife	Key informant	23 Mar. 2010 at the MOH office, Attidiya	Sinhala
Pushpa	Public Health Midwife	Key Informant	23 Mar. 2010 at the MOH office, Attidiya	Sinhala
Wasana	WWC attendee	Interviewee	8 Apr. 2010 at her residence in Kotalawalapura	Sinhala
Wasana's mother		Interviewee	8 Apr. 2010 at Wasana's residence in Kotalawalapura	Sinhala
Hareena	WWC Attendee	Interviewee	23 Mar. 2010 at her grocery shop in Attidiya.	Sinhala

Please note that in order to preserve the anonymity of the Key informants and interviewees I have used either their designation or pseudonyms in the text. I have given a brief biographical note below on some of the Key Informants that contributed to my study.

Biographical Notes on some Key Informants

1. The Retired Secretary of the Ministry of Plan Implementation (1977-1986)

He had studied at Royal College (One of the most prestigious boys' schools in Sri Lanka built during the British period) and graduated with a LLB (Honours) degree from University of Ceylon. In 1972 he obtained his PhD from the London School of Economics and joined the Monash University in Australia as a senior academic. He was called to serve as Permanent Secretary of The Ministry of Plan Implementation in 1977 by the newly elected President Mr. J.R. Jayawardene. After implementing a dynamic population control programme through the Ministry of Plan Implementation he retired from government service in 1986. Currently he is serving as Sri Lanka's first Insurance Ombudsman.

2. Retired Minister of Health (1972-1977)

She is from an aristocratic family from Pelmadulla (in Sabaragamuwa Province in central Sri Lanka). She studied at Ladies College Colombo (one of the oldest Christian Missionary Schools in Colombo) and soon after finishing school she married James Peter Obeyesekere III in 1948 at the age of 19. He belonged to another aristocratic family from Nittambuwa; the Obeyesekere, Bandaranaike families. He assumed duties as Minister of Parliament for Attanagalle after his cousin, S.W.R.D. Bandaranaike's assassination (1960 – 1964). She helped him in his political work.

However, she herself was a founder member of the Sri Lanka Freedom Party (S.L.F.P) together with her husband. She entered into politics in 1965 by contesting the Mirigama seat. She was the Minister of Parliament for Mirigama from 1965 – 1977. In the intention of promoting local hand craft she started Kalapura in Kandy and then Laksala in Colombo in 1964. She has travelled to over 50 countries to promote handicrafts. Her work in handicrafts, uplifting the lives of thousands of poor craftsmen won her recognition from President Jayawardene and President Ranasinghe Premadasa. The latter gave her the Deshamanya title.

She was also the Minister of Health in Mrs. Bandaranaike's government (from 1972-1977). During her time the slogan for family planning campaign was "Two is enough Three is a luxury". The campaign was a great success.

3. Retired Executive Director of the Family Planning Association of Sri Lanka (1975-2005)

He joined the FPA in 1973 and became the first executive director of the FPA in 1975. Before he joined the FPA he worked as an executive at the Ceylon Cold Stores. He introduced a number of initiatives during his long tenure of 30 years. Volunteer programme is one of the most popular and effective programmes that he introduced. He went through rough times during JVP insurgencies in 1989. He is remembered by his colleagues as an energetic man with a vision of his own.

4. Retired Medical Director of the Family Planning Association of Sri Lanka

Her mother is one of the pioneer members (elite women who attended the tea party at Mrs. Fernando's residence in Colombo) of the FPA of Ceylon. As a young medical student in the 1970s she was determined to help poor women in Sri Lanka as her mother through family planning. She took over from Dr Siva Chinnatamby when she retired as the medical director of the FPA. Taking Dr Chinnatamby's footsteps she also committed herself to number of research initiatives. Postinor 2 was introduced during her tenure. She also went through rough times during JVP insurgencies in 1989.

5. WWC Programme Director UNFPA, Colombo Office

She is a very energetic lady educated at a leading Girls' School in Colombo. She is permanently attached to the Maternal Health Division of the Ministry of Health. When I interviewed her in 2010 she was at UNFPA on a 2 year contract. She has worked in Badulla (central highlands of Sri Lanka) as the MO/MCH in the 1990s.

6. Former Dean, Faculty of Medicine, University of Colombo (One of Dr Chinnatamby's students in the early 1970s)

I interviewed him when he was the Dean of the Faculty of Medicine, University of Colombo. Educated at a leading Boys' School in Colombo, he entered the medical faculty of the University of Colombo in 1967 and joined the faculty as a lecturer in 1975. Obtained his post graduate qualifications from UK in 1978 and rejoined the department of Obstetrics & Gynaecology, University of Colombo as a senior lecturer. From 1991 to 1999 he held the headship of the department of Obstetrics & Gynaecology and then became the Dean of the faculty from 2008 to 2011.

He was engaged in family planning research from his early days as a student at the Medical Faculty. Today he is one of the well respected gynecologists in Colombo.

7. Former Director of the Population Division in the Ministry of Healthcare and Nutrition

He is attached to the Institute for Health Policy in Colombo as a Senior Fellow. After obtaining a Masters degree in Population and Development from Cornell University and a PhD in Population Planning from the University of Michigan he joined the government of Sri Lanka and served in the Ministries of Economic Planning and Plan Implementation for 38 years. He had published widely on different issues on population in both local and international journals. Also he had worked in the capacity of evaluator and consultant to the ILO/IPEC, UNDP and UNESCAP.

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